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ABSTRACT

This is the report of a study undertaken by the Institute of Rehabilitation Issues to identify unique problems in rehabilitation services delivery to inner city nonwhite clients. Chapter 1 reviews the literature on vocational rehabilitation for people with mental and physical disabilities and points out the lack of research on nonwhite, lower class populations. In Chapter 2, the nature of support systems are defined, and ways that vocational professionals can serve as resources in utilizing community support systems and improving services to inner city nonwhite clients are suggested. The third chapter of the report discusses problems in the delivery of services to the severely disabled in urban areas, including bureaucratic factors and cultural differences between counselors and clients. Chapter 4 examines regulatory and programmatic requirements within Federal and State programs that serve as disincentives to the successful rehabilitation of disabled clients. The fifth and final chapter focuses on the lack of public understanding of vocational rehabilitation programs and discusses what might be done to improve public awareness. Appended to the report are the text of a cooperative agreement between one community center and a vocational rehabilitation program and a guide to planning and evaluation for identifying and recruiting priority clients. (GC)

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Delivery of Rehabilitation Services to Inner City Nonwhites

RESEARCH AND TRAINING CENTER
UNIVERSITY OF WISCONSIN-STOUT
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MENOMONIE, WISCONSIN

JUNE 1981

Report from the Study Group on

DELIVERY OF REHABILITATION SERVICES TO INNER CITY NONWHITES

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PREFACE

Delivery of Rehabilitation Services to Inner City Nonwhites was one of three study topics for the 1980-81 cycle chosen by the Institute of Rehabilitation Issues Planning Committee at its annual meeting September 9-11, 1980. The topic was assigned to Prime Study Group II. In addition, the following guidelines were agreed upon by the Planning Committee for consideration by the Prime Study Group in development of the topic:

Purpose:	Identify unique problems of service delivery to inner city nonwhite clients and suggest strategies for the amelioration of these unique problems.
Focus:	The Prime Study Group should keep a rehabilitation orientation and guard against the urge to discuss at length the social logical and economic problems of the inner city resident. Only those problems that can be addressed by rehabilitation measures should be discussed. It is felt that a group by group discussion of the ethnic and racial differences of specific groups would be counter-productive. Rather, similar problems across groups should be the primary focus, only highlighting unique differences between groups with specific examples of problems and how they were solved.
Specific Charges:	Provide a statement of the problem from a historical perspective.
	Discuss characteristics of the group as contrasted with other rehabilitation client groups.
	Discuss administrative, supervisory and counselor issues and give recommendations.

The mere fact that this topic, Delivery of Rehabilitation Services to Inner City Nonwhites, was chosen for study by the Institute of Rehabilitation Issues indicates that (1) a problem exists and (2) change is needed. The purpose and charges give further indication to where the problem exists and who must introduce the change. While change

is often necessary, it may be well to recognize that the human ego sometimes creates an almost impenetrable barrier to the implementation of change. So often, many of us who have the most difficulty in introducing change, are the ones who subconsciously resist it. Yet, so dynamic is the period in which we live, that many leaders in the vocational rehabilitation profession, in viewing the future, have remarked that the only constant is change.

Every profession is concerned with the use of knowledge in the achievement of objectives and, often, with the need for change. Committed individuals who strive for competency in our chosen profession of vocational rehabilitation are constantly seeking knowledge. The attaining of knowledge invariably creates a concern for change. Yet, too often, we allow others outside our profession to recognize and propose change for us - change that is based on knowledge that we already have, but fail to use in the achievement of our objectives.

Could it be that we are remiss in recognizing the anatomy of a decision: alert, analysis and action? Do we fail to get ready to sell, identify resources, anticipate objectives, sell benefits, listen in depth and follow-up? If so, it becomes apparent that it is not enough that we are only concerned with change; we must become expert at management of change.

Competition, of course, stimulates much change. To compete, we must constantly improve our methods, technology and productivity. As Prime Study Group II began to develop this document, several key areas were considered as worthy of improvement in order to effectively serve the inner city nonwhites. These were: how our rehabilitation agencies can integrate services to the disabled of the inner city; how the service

delivery system can be modified to accommodate nonwhite clients; the disincentives of rehabilitation to nonwhite clients; and what we can do to improve public image.

Prime Study Group II has taken the position that federal officials, state directors, supervisors and counselors all share a major role in implementing change in the above mentioned significant program areas. Prime Study Group II also stands firm in its belief that true professional help as typified by the exceptionally sophisticated and sensitive individual in any professional field, consists of placing the professional's knowledge and skills at the client's disposal. It is toward this end that this document addresses itself.

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CHAPTER I

CHAPTER I

INTRODUCTION

Vocational rehabilitation has not experienced much success in rehabilitating Americans in minority groups, particularly nonwhites, and particularly if they are severely disabled and living in inner cities or pockets of poverty. The Federal/State vocational rehabilitation program has experienced great difficulty in adapting to the needs of severely disabled client populations. These needs have generated new nontraditional approaches such as the relocation of facilities and offices within those areas of major cities where large clusters of the poor and nonwhite reside, often called ghettos or the inner city, and the development of special caseloads consisting mainly of these inner city disabled residents. Inspite of these and other program modifications, difficulties in identifying, enrolling and rehabilitating the inner city resident still persist and leave large numbers of nonwhite and impoverished handicapped individuals outside the mainstream of employed Americans. While there have been some successes in serving the inner city severely disabled nonwhite clients, the success is limited, and the track record in serving these most vulnerable of all clients has not fared well.

While it is not possible to draw a "typical" picture of the inner city disabled from available Census Bureau data (1973), it is well documented that Blacks are underrepresented or disadvantaged in virtually every important facet of American society -- employment, income, education, living conditions, health status and so forth. Specifically, more Blacks than whites are unemployed (13.1% vs. 5.2%) and have lower average weekly earnings ($171 vs. $217). Fewer Blacks complete four years of high

school (43% vs. 63%) and more Blacks are below the poverty level (31% vs. 9%).

While Blacks comprise about one quarter of the population of large cities, they comprise over one half of the population in low income areas. Low income areas also contain a disappropriate number of persons who have a Spanish language background, and this group comprises only 9% of the total population but 16% of low income area residents (Bureau of the Census, 1973).

Based on a 1972 Social Security Survey of disabled, Atkins and Wright (1979) reported findings by Allan (1976) that "Black persons were about one and one half times more likely to be disabled than whites. Thus, 21% of Blacks and 14% of whites reported that they were disabled... Blacks were twice as likely to be severely disabled."

In addition to the above problems, poverty (inner city) areas are typically areas of higher rates of physical and mental disabilities. Keyserling (1965) points out that "the proportion of those disabled or limited in their major activity by chronic ill-health rises sharply as income sinks."

Williams (1971) conducted a study of disabilities in a Black community in Austin, Texas, and found that 42.6% of 516 households had one or more disabled members above the age of 15 years. This represents approximately 27.5% of all persons above the age of 15 years. When persons over the age of 64 are deleted, 10.5% of the remaining population was still identified as disabled.

In another study, the Michigan Bureau of Rehabilitation (1979) compared characteristics of rehabilitation clients in Detroit districts with outstate Michigan (i.e., all other Michigan rehabilitation districts),

and found that the Detroit districts were predominantly black while outside districts were predominantly white. Moreover, the Detroit districts had a higher percentage of clients classified as mentally retarded, a higher percentage of traditional disabilities, e.g., visual, hearing, orthopedics, (32.4% vs. 22.8%) and a higher percentage of more socially oriented disabilities, e.g., emotional, alcoholism, drug addiction (31.7% vs. 22.8%).

In still another study conducted in 1965 by the Michigan Bureau of Rehabilitation, Halter and Tinning (1968) point out that in both national and state vocational rehabilitation statistics, the level of retardation is about 7% of total caseloads, whereas in the inner cities in Michigan, mental retardation reaches a level of 25%.

Urban Migration and Pockets of Poverty. Over the past decades, substantial population shifts have occured within the urban centers of the country. These shifts have been mainly along economic, racial and ethnic lines. As the more affluent white middle class has moved out of the cities into surrounding surburban areas, increasing numbers of blacks and Hispanics have moved into larger cities joining the remaining poorer white ethnic groups.

The diminishing tax base resulting from the decrease in middle and upper class residents of the city has given rise to serious social and political problems. These are often reflected in deteriorating health conditions amongst the remaining populace as well as poor housing and increasing incidents of disability, both physical and mental.

New and acceptable life styles have emerged within the city which reflect the cultural and economic changes. Traditional middle class approaches to family, education, work and preventive illness have often been replaced by less definable styles to the middle class and not

particularly related to the Judeo-Christian work ethic so prevalent through much of the early twentieth century.

In these population shifts, many minority persons have moved from rural to urban and industrial ways of life, and from one enclave of poverty to another: While bringing with them social institutions like the extended family; where close relatives and friends live and work together; which is more suitable to and facilitative of an interdependent rural life. In crowded urban areas, as well as in rural pockets of poverty which depend upon resources and exchanges in the urban area for survival and well-being, this life style is difficult to maintain. The frustrations leading to the breakdown of the extended family are accompanied by such debilitative behaviors as desertion, alcohol and substance addiction, physical and mental illness, child and spouse abuse, educational disability and attrition, and delinquency and crime.

Frustration of Needs and Time Orientation. Because of the frustration of lower level needs -- physiological, safety and belonging, many minority persons are present-oriented, working hard when work is necessary and available to realize specific, concrete and rather immediate objectives. Also, because they have failed to realize or been blocked in realizing past aspirations, they see little hope or real value in delaying gratification to build for the future. Furthermore, efforts to achieve significantly greater than other family members and peers may be frustrated by jealously, gossip and rejection. As a result, strong and sustained competiveness, in both work and play, are frequently and significantly diminished.

Although the vocational rehabilitation program has been in existence at the state and federal level since 1918, it was only during the turbulent 1960's that the program began to address and focus on the specific

needs and problems of handicapped minorities who lived in the inner cities.

Since vocational rehabilitation is a program of national dimensions reaching into every state, county and city in the nation, it could not help but be influenced by the direction of the economics and social developments. Consequently, during the 1960's, the vocational rehabilitation program was challenged to bring to the problems of the poor and culturally and socially disadvantaged in the inner cities the concepts, the philosophies, and the methods on which vocational rehabilitation had grown without abating its concern for the physically and mentally handicapped.

In 1969, The National Citizens Advisory Committee Report called for continued expansion of the vocational rehabilitation program and the need to devise better ways for using the program for those individuals disadvantaged or handicapped primarily by social, educational, racial, economic and other nonphysical handicaps. The committee also proposed a change in the federal law to make clear that vocational rehabilitation services are available to any individual who is under a clear vocational handicap, regardless of the cause of the handicap (but retaining a focus on those with physical and mental disabilities as the major thrust of the program).

In reviewing vocational rehabilitation's role in the 1960's and 1970's, it should be remembered that there were as many responses to rehabilitation of the handicapped in the inner city as there were state agencies. Whereas, one state agency may have been innovative and creative, another may not have been. Consequently, the vocational rehabilitation program as a whole can neither be condemned nor applauded because of what one or even several state agencies did or did not do. Nevertheless,

it can be said that the vocational rehabilitation program, in general, attempted to respond to the needs of the time.

Greater efforts were made to reach inner city handicapped through increased outreach activities. These included the hiring of Hispanics and other non-English speaking minorities, and efforts to sensitize the counselors to the culture and problems of inner city handicapped persons.

While much remains to be done, the available evidence indicates that state agencies were aware of the needs of minority clients and attempted with varying degrees of success to meet those needs. Indeed, many state agencies decentralized and dispersed vocational rehabilitation offices in major population centers for the purpose of providing services in neighborhoods where disabled people live and many established one-stop multi-service rehabilitation centers in ghettos and other areas where the incidence of disability was high.

Some agencies experimented with the training of indigenous rehabilitation aides to expand the effectiveness of the professional staff in providing services to the disabled in the inner city and to bridge the gap between the people and the vocational rehabilitation agency.

There was little success, for example, in resolving some of the disincentives that prevented some clients from participating in the program. For example, if clients received maintenance or other support from vocational rehabilitation, they were frequently faced with the prospect of having a reduction in housing subsidy, food stamps, medicaid benefits, and so forth. Many of the disincentives still persist and await a greater effort on the part of federal and local officials to resolve them.

Although vocational rehabilitation and the WIN (Work Incentive) Program entered into cooperative agreements in many states, all too often

the training provided by WIN was inadequate and left clients unprepared and unqualified for jobs as they were before the training. An enormous amount of time and money were wasted on many fly-by-night technical, vocational and business schools that were not accredited and did little to advance client employment prospects. Vocational rehabilitation is now faced with a public that has a global perception of social service oriented programs as being inefficient, ineffective, wasteful and rampant with fraud. There is a very real danger that "the baby will be thrown out with the bath water," and programs that have proven their worth will not survive.

Many of the programs, particularly the large and controversial ones, were directed toward economically disadvantaged blacks. Later, other groups were added, e.g., Spanish-speaking persons, Native Americans and so on. Cutting across all these groups, there was a major effort to address the needs of handicapped persons. In a sense, there were <u>experimental programs within experimental programs</u> in that untested models were being applied to economically deprived groups, and at the same time, untested vocational rehabilitation efforts were being applied to handicapped persons within all disadvantaged groups.

Despite the large sums of money expended on these programs, a review of the standard literature and data have yielded no studies that attempted to evaluate the effectiveness of the programs in terms of any traditional criteria such as cost-benefit, effectiveness, efficiency and so on.

Two other elements were also conspicuously missing in many of these programs. They were high standards (i.e., credentials, loyalty and demonstrated skills of administrators and staff) and traditional strict budget and accounting procedures. With respect to the latter, one administrator who had been indicted for misplacing funds, stated that the accounting

requirements of his programs were so loose that "Abe Lincoln would have stuck his hand in the till as well." It seems, then, that the programs were "arranged" to fail as the "prophecy of the framers" was fulfilled. Despite all, and as many clients and counselors will attest, many inner city handicapped persons were positively affected by the programs. Perhaps, this is the only evidence or proof of effectiveness that is necessary.

The Rehabilitation Act of 1973 (PL 93-112) redirected the Vocational Rehabilitation program to focus on individuals with the "most severe handicaps" and required that each state plan show how persons receiving services would be served first. A severely disabled individual was defined as "a handicapped individual who has a severe physical or mental disability which seriously limits his functional capacities (mobility, communication, self-care or work skills) in terms of employability." Because the inner city nonwhite severely disabled clients are, perhaps, the most disadvantaged of the severely disabled, they present a special challenge to vocational rehabilitation and should be given rigorous time, effort and resources to meet the service delivery priority mandate of the law.

By focusing on program evaluation and the ways it can facilitate the viability of the vocational rehabilitation process and outcomes for the severely disabled inner city nonwhite population, vocational rehabilitation will develop major benefits, including:

1. Valid and reliable criteria and measures needed for determining severely handicapping conditions.
2. The most significant dimensions of client outcomes.
3. The effectiveness of various methods of outreach, referral, and intake to the vocational rehabilitation system, including the effectiveness and costs of saturation services.

4. The relative effectiveness of contrasting service delivery methods that are feasible in vocational rehabilitation agencies.

5. The effectiveness of vocational rehabilitation services in increasing the employability of handicapped persons and in providing other benefits to clients.

6. The relevance of program evaluation findings to program decisions and activities.

7. The viability of regular case reviews.

Evaluation of the effectiveness of vocational rehabilitation services to the severely disabled inner city nonwhite client group is an acid test of the effectiveness of the vocational rehabilitation system. Questions which should be answered by this evaluation include:

1. What reasons do minorities give for not seeking vocational rehabilitation services?

2. What are the experiences of minorities who seek vocational rehabilitation services?

3. How do minority persons view overcoming the handicapped effects of disabilities and the effects of disablements on their survival, well-being and development?

4. How do cultural and racial differences influence the utilization of vocational rehabilitation services?

5. What do minority persons perceive as barriers to the availability, accessibility, acceptability and and adequacy of vocational rehabilitation services?

6. What adaptations need to be made in the vocational rehabilitation system to facilitate the access and development of minority persons?

7. What are appropriate points of entry to vocational rehabilitation services for the disabled located in minority neighborhoods and enclaves of poverty?

8. What self-help and support services and systems are available to minorities, and how can they be employed to achieve vocational rehabilitation objectives?

The delivery of effective vocational rehabilitation services to inner city nonwhite severely disabled clients will improve the service delivery system for all client groups. Put another way, when the delivery of vocational rehabilitation services becomes viable for the severely disabled inner city nonwhite clients, the delivery system will be a more viable system for all clients.

Moreover, the knowledge gained as a result of effective delivery of services to the severely disabled inner city nonwhite population will provide guidelines for the enhancement of administrators, supervisors and counselors in the service delivery system, including the selection, retention and development of rehabilitation personnel. Such knowledge will be useful in fine-tuning the service delivery system.

It is in the national interest to develop the most disadvantage of human resources, and the severely disabled inner city nonwhite clients is such a group. In this light, consider the arguments made by Arthur R. Brayfield (1968) for the development of black human resources in a testimony before a congressional committee:

> The major test of a democratic society is its ability to provide opportunities and the social structure which will enable its members to recognize, develop and utilize their human potentialities. In our American society, we have come some distance toward accepting and, to a lesser extent, fulfilling this goal. In recent years we have been brought closer to fully embracing this goal because of our growing realization that we cannot survive as viable society unless we resolve the problems associated with caste and class. There is some public understanding and some public recognition that we are indeed a caste and class society, and we are beginning to cope with this reality at painful cost.

CHAPTER II

CHAPTER II

VOCATIONAL REHABILITATION AS AN INTEGRATIVE FORCE IN THE MAXIMIZATION OF RESOURCES

INTRODUCTION

Traditionally, vocational rehabilitation has recognized community involvement as a viable means to aid the agency in achieving desirable rehabilitation outcomes for handicapped citizens. It is the consensus of this Prime Study Group that active involvement in the inner city nonwhite community by vocational rehabilitation professionals has a direct bearing upon successful rehabilitation of inner city clients and is an aspect of the service delivery program that can ill-afford to be neglected.

According to the American Heritage Dictionary of the English Language, a resource is defined as (1) something that can be turned to for support and help and, (2) an ability to deal with a situation effectively.

In light of the above definitions, this chapter will (1) explain the nature of support systems which exist in nonwhite communities, and (2) suggest ways that vocational rehabilitation professionals can indeed be also defined as a resource in utilizing community support systems and improving services to inner city nonwhite clients.

STATEMENT OF THE PROBLEM

Similar to other groups and communities, inner city nonwhite citizens have developed a variety of support mechanisms for providing mutual aid and help to its residents. Traditionally, however, vocational

rehabilitation either because of a lack of knowledge or insensitivity, has not recognized the nonwhite community as a resource in enhancing efforts to rehabilitate inner city nonwhite clients. Also, unfortunately, many vocational rehabilitation professionals do not understand or appreciate the support system that exists in nonwhite communities. For the most part, rehabilitation research literature has either tended to ignore this aspect of nonwhite communities or has given it very little attention. Often too, what is found in the literature, are the so-called weaknesses of inner city nonwhite communities that hinder rehabilitation efforts, rather than the strengths that enhance efforts. In effect, meaning of the the term "bridging the gap," has not yet been applied to nonwhite communities. As a result, inner city nonwhite clients are not receiving the services they should receive from vocational reahabilitation agencies, and culturally relevant rehabilitation services have not, for the most part, been provided.

DISCUSSION

It is believed by many people in our society that one reason that nonwhites have been able to survive in this society is related to their own efforts to solve problems. Specifically, nonwhites have a support system and this system has played and can play a bigger role in helping to resolve many of the problems confronting the inner city nonwhite client. However, the proper linkages between the vocational rehabilitation agencies and community support systems in the nonwhite community must be formed in order that benefits can be derived. If vocational rehabilitation is not visible to the the nonwhite community and the agency and support systems are working in isolation of each other, a holistic approach to

rehabilitation efforts cannot be realized. Inner city nonwhite clients visit governmental agencies and have to deal with, for what must be for them, a totally irrational system that treats their needs as separate and separable problems. The rehabilitation needs of inner city nonwhite clients cannot be properly assessed in a vacuum. Therefore, professionals must view the rehabilitation needs of inner city nonwhite clients within the context of the total cultural and societal systems as well as within the perspective of the inner city nonwhite community.

What is a support system? According to Caplan (1974), it can be defined as: "Continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validation of their expectations about others, which offset deficiencies in these communications within the larger community context."

Some authors refer to the support system as networks (Mitchell, 1969; Bott, 1971; Craven and Wellman, 1973). For example, Mitchell (1969) gives the following definition of networks: "A specific set of linkages among a defined set of persons, with the....property that the characteristic of these linkages as a whole may be used to interpret the social behavior of the persons involved."

Elaborating on the concept of network, Craven and Wellman (1973) stated that: "Units linked together to form a network need not necessarily be individual persons but may be other, larger social units as well...."

Collins and Pancoast (1976) states, "A support system or a social network consists of people and relationships." If we add the word helping, then, support system deals essentially with the relationship or attachments among people which results in their helping each other to solve certain types of problems.

Given our definition of a support system, it is clear that nonwhite communities have developed comprehensive support systems. With the myriad of problems facing inner city nonwhite clients, it has not been possible for social services and vocational rehabilitation agencies to meet all their needs. However, with proper linkages formed between vocational rehabilitation agencies and nonwhite community support systems, unmet needs of inner city nonwhite clients may be met.

Described below are some support mechanisms existing in the nonwhite community. The intent here is not to give a "laundry list" of services and organizations, but rather to provide to the reader an awareness of the nature of support mechanisms in the nonwhite community and how they impact on nonwhites. It is only through outreach and visibility on the part of vocational rehabilitation professionals in the nonwhite community that we can hope to maximize resources for inner city nonwhite clients.

SUPPORT SYSTEMS IN THE NONWHITE COMMUNITY

Voluntary Organizations

Within the nonwhite community, voluntary organizations have evolved in response to the needs of its residents. These organizations have not been designed for handicapped individuals specifically. Because of the nature of their existence, however, they often provide services for handicapped individuals. Historically, in the nonwhite community much emphasis was placed on mutual aid. Staples (1976) states that "White Anglo-Saxon norms dictate individualism and competition. Nonwhites tend to believe that they should help anyone in need. They have faith in the spirit of cooperation rather than competition. This value is reflected in their views on poverty, welfare and the ill-fed, and their exchange network."

This mutual aid value is seen at the individual level in Stack's (1974) study of low-income mothers in a community outside Chicago. It is also seen at the organizational level as reflected in fraternal societies, social clubs, civic associations, political organizations, and professional associations. According to McPherson (1971), "Next to the church, the fraternal and mutual benefit societies were the most important social institutions in the nonwhite community...."

Studies have repeatedly shown the relative importance of Black organizational efforts for solving social and community problems (Jones, 1977; Tomeh, 1973; McPherson et al., 1971). According to Tomeh (1973), "Studies.... show higher participation rates for Blacks at all social levels, especially lower class. For whatever reasons, Blacks have indeed become joiners. The rise of a wide range of Black associations in recent years indicates that voluntary associations are not the preserve of white middle class... Whatever the case may be, the response of Blacks to segregation appears to be quite the opposite of indifference and apathy."

Many local affiliations of national nonwhite organizations provide services for inner city residents. Some of these are civic, social, fraternal and social service groups. While the nature of the organizations may differ, they all may be found to be contributors to the lives of inner city residents.

In many cities, there are local chapters of black sororities and fraternities such as Alpha Kappa Kappa, Zeta Phi Beta, Delta Sigma Theta, Alpha Phi Alpha, Kappa Alpha Psi, Omega Psi Phi and Phi Beta Sigma. The major thrust of these organizations is public service to the inner city community. They are involved with providing and/or coordinating public

service projects for nonwhite community residents. Some of these services provided are day care, clothing, scholarships and career day programs. For example, in one major urban city, a chapter of Delta Sigma Theta Sorority obtained a grant to fund a housing complex for senior citizens and handicapped individuals. These organizations also honor individual requests for services.

Masonic groups such as the Prince Hall Masons and its female counterpart, Order of Eastern Star, can be found in most urban cities and are committed to providing services to inner city residents. These groups have a history of providing academic scholarships and making financial contributions to various community projects.

Black women's clubs, both civic and social such as the National Council of Negro Women, Links, and others have given assistance to organizations that serve inner city nonwhites and to inner city nonwhite residents, themselves. Many Black women's clubs are also very active in providing social work and mental health services to nonwhite communities.

Other more widely known national organizations such as the National Association for Advancement of Colored People (NAACP) and National Urban League also provide servcies to inner city nonwhite communities. In fact, the National Urban League came about as a direct result of problems inherent in the inner city community. Most chapters located in urban settings have projects that involve vocational guidance and counseling, job placement, problems with youths, recreation, housing and health.

In one major urban city, the local Urban League has created a disabled veteran project. The goal of the project is to seek employment for 100 disabled veterans. Linkages have been formed with major businesses in the community. Some business leaders in the city also serve as

members of the project's advisory council. A rehabilitation counselor active in the nonwhite community serves on the advisory council and has integrated her agency's services with the services of the League.

Another project sponsored by the local Urban League involved youth. This was a support project designed to help families and troubled youth in crisis meet their responsibilities to themselves and to each other. The project employed family counselors, who provided family counseling, needed medical services, tutoring services, better housing for the entire family, and emergency shelter, when necessary, in private homes for the children of the family.

Other projects included a public service employment program, reading aides for the blind, a youth leadership development and training program, a work experience program, and a program for female heads of households which focused on consumer issues, and child care as a means of freeing women for jobs.

The Church

The Black church serves as a support system for Black people. This support system is carried out as follows (Staples, 1971):

1. The maintenance of family solidarity (conserver of morals, a strengthener of family life, final authority on right or wrong).
2. Status conferral (sense of recognition and "somebodiness" for the janitor and domestic as well as the teacher, social worker or professor).
3. Leadership development (ability to hold a variety of positions).
4. Center of Black protest.
5. Expressive function (release of tension).
6. Social intercourse and amusements.

In effect, the church in the inner city is a self-support cultural-maintenance organization that assures the inner city resident cultural survival and emotional support.

Churches in the nonwhite community become actively involved with the problems of inner city dwellers. One example is of a church in an urban community that has created a "Human Services Center." A function of the Center is to provide counseling services to members of the community in areas of family and marital problems, health, housing, drug abuse and consumer education.

The church in the inner city is also a political force to be reckoned with by local legislators. By virtue of their large constituency, they usually capture the attention of political figures in the community, particularly at times of political campaigns. Within the Church community, there is usually a "gatekeeper" that is, a minister who is, in effect, the leader of all the other ministers. The "gatekeeper" is a powerful resource to have when advocating for handicapped individuals in the community.

The Family

In inner city nonwhite communities strong kinship networks exist. The family unit may be one that is described in some literature as an extended family. The unit may be composed of family other than mother, father and children. The unit may also be composed of individuals who are not related. In rehabilitation literature, the term "significant others" may be similiar. Studies have shown that the extended nature of nonwhite families provide benefits to the family unit such as child care, financial aide, advice, guidance and a high level of interaction among adult members and children in the family structure. Rehabilitation

practitioners should first be aware that such family structures do exist. Then practitioners must understand and appreciate adaptability skills inherent in such a structure. In attempting to involve family members to assist in efforts of rehabilitation, it is important to be able to identify and assess the decision making tasks in the families.

Community-Based Programs and Business and Professional Groups

The inner city community is composed of many organizations such as day care facilities, senior citizens clubs settlement homes, all of which provide services to inner city residents. In addition, many business people in inner city nonwhite communities such as dentists, doctors, realtors, bankers are usually members of neighborhood business and professional groups. When approached, they often make contributions to the inner city projects. Many members of these organizations are non-white and also carry a commitment to inner city residents. In addition, there exists in many urban cities such organizations as The National Association of Black Social Workers and Psychologists, National Alliance of Black Business Men, and other nonwhite professional organizations.

Political Organizations

Inner city nonwhite communities also have legislators who represent particular districts. In addition, some urban cities have neighborhood advisory councils whose primary responsibility is to make known the needs of inner city residents to local legislators.

Opinion Leaders

Some groups exist in inner city nonwhite communities without structure. Such people as neighborhood bartenders, barbers, entertainers, and pool hall owners have played important roles in promoting racial identity and group loyalty in nonwhite communities. Racial loyalty and group identification

is a value that serves as a coping strategy for nonwhites and transcends into feelings of positive self-worth. In many instances, these opinion leaders know the "heartbeat" of the community and can be instrumental in assisting rehabilitation professionals in designing culturally relevant programs.

ASSESSING THE INNER CITY NONWHITE COMMUNITY

The above heading does not suggest that the inner city nonwhite community is difficult to access. To the contrary, knowledge, sensitivity, awareness and acceptance of a culture that may differ from one's own and a sincere commitment to formulate meaningful relationships is all that is required. Two key ingredients of effective service delivery to the nonwhite community worthy of consideration are visibility and communications.

Visibility

An office should make every attempt to be accessible and visible to the local community. The efficiency and ease of facilitation of the service delivery system, made possible by office location in the inner city is very important. But equally important is the impact vocational rehabilitation can have on the socio-cultural change of the community as well as on the individual client. As noted by the Second Institute on on Rehabilitation Issues (1975), commenting on the Delivery of Rehabilitation Services, "... visibility is related to the utilization of services, level of public confidence, accountability to the public..." Rehabilitation has come to mean more than placing a person in employment.

It is a reality that the inner city communities on a whole are becoming more and more economically depressed. Dr. Harvey Brenner noted

that,"...even a one percent increase in unemployment creates a legacy of stress, aggression and illness affecting society long into the future." To have the expectations of cooperation and motivation from candidates for rehabilitation services and not be present in the community in a supportive role is tantamount to an insult to that community.

The task before rehabilitation agencies is to recognize that the provision of services to different cultural groups should not be structured and provided the same as those to urban groups. The environments are different and therefore the attitudes, beliefs, values and behavior will correspondingly be different. Rehabilitation agencies are agents of change; change in the handicapped individual's lifestyle. The more the lifestyle is different from that in which the client is expected to interact (such as the employment site or even in interfacing with the counselor in the district office) the greater the effort needed for motivation for change on the part of the client. Essentially, the solution to rehabilitating the inner city client is a matter of perception: how the client perceives the counselor, and the rehabilitation agency for which that persons stands, and vice versa. When a client can perceive an agencies willingness to help (Vontress, 1971), then trust and confidence can be established to start the resolution of problems.

Many state rehabilitation agencies and many city offices elect to provide outreach to the inner city population through "satellite" stations. These are contact offices in other social service establishments, community buildings, or churches. The disadvantage with this arrangement is that it does not provide for continuity of contact, if the satellite office can only be open on certain days. Also, the advantage of the permanent office site over a satellite setting is the advertisement of

the state rehabilitation agency through a prominent sign as opposed to a possible listing under the heading of another agency, or no listing at all. If these are the only arrangements that can be made to interact with the inner city, then it is far better than having all clients travel out of their area to an office to receive services.

The outreach in those circumstances should of necessity be itensified through more public relations activities in the inner city to advertise the agency's intentions. The risk is greater in attracting and keeping this clientele group if "long distance" contact has to be resorted to. Many inner city residents, particularly the handicapped, have neither the money nor the stimulation to extend travel more than a few blocks.

Communication

The greatest barrier to effective communication with inner city poverty persons is the presence of preconceived and unfounded blanket sterotyping of these residents. Because it is hard hitting for necessary emphasis, most of this section includes excerpts from Pouissaint (1969). The report should be read in its entirety for a more comprehensive view of the writer's perception. Dr. Poussaint states:

> ... We should realize, by now, that much of the inability to establish meaningful contact with "poor" people is due to certain class attitudes that most professionals have absorbed from the American culture. Firstly, most middle-class folks do not respect the poor and consider them inferior beings. In our society we live by the Protestant ethic which says any man can be successful through industry and hard work. Those, then who are poor are "failures" who have no one to blame but themselves. It is strongly implied that poor people have some fault of character or moral weakness.
>
> Can a social worker perform effectively with a poor client if these feelings are harbored?
>
> ... How much are we inwardly rejecting people who do not

wear the "proper" clothes or who use "bad" ungrammatical speech?

Does the culture condition us to view all poor people as inferior? Is there a "classism" in America that operates in a similar manner as "racism?"

... It is clear that if a poor person is able to perceive personal rejection due to "class supremacy attitudes" in professionals then there can be very little honest communication, just as there is very little honest dialogue between blacks and whites because the society is pervaded with white supremacist attitudes. It's very difficult for whites in this country to psychologically put themselves in the shoes of a Negro and feel what it's like to be black. It is also as difficult for professionals to put themselves in the shoes of the poor - to understand and have empathy with them?

We know that one of the most important factors that facilitates communication for professionals is to have a sincere interest and empathy for their client. A client perceiving this respectful concern will ease many of the barriers to communication despite social class differences. But the empathy must be based on mutual respect and not condescension.

... It's been observed that one of the factors that blocks mutual communication is the combination of attitudes which accompanies feelings of superiority in a professional who is good-intentioned. These attitudes generally go under the heading of paternalism. Paternalism is a supremacist condescending approach that is not basically respectful of the other person. It may encourage us to do a lot for the poor but little with the poor. We may like to tell them what is good for them but rarely allow them to have decision-making power over the institutions that service them, and we may continue to encourage their helplessness.

How often are we intimidating the poor into dependency and withdrawal by our own attitudes and behavior? The poor are second class citizens in America but are far from just innocent bystanders.

What then can professionals do to facilitate communication: First, as already outlined, they must examine their own stereotypic and prejudicial attitudes towards "the poor" and practice "putting yourself in the other person's shoes."

Second, they should avoid missionary approaches and paternalism but, rather, build relationships based on mutual respect and empathy. Third, they should acquaint themselves with the subculture and life-styles of the

groups they are working with and then modify some of their own techniques and approaches. Fourth, professionals should involve the community and the poor in decisions regarding services that affect their lives. Community aides should be used as a bridge between the poor and the professional and the agency.

Following these few suggestions will not eliminate all of the difficulties in "communicating with the poor," but they will, at least, help to establish a dynamic framework in which many of the inherent problems can be constructively approached and solved.

A DAY IN THE LIFE . . .

CLIENT (to himself):

I went to the Department of Vocational Rehabilitation two months ago...I don't have a place to stay...no food...no money to go look for a job...the counselor told me I had a disability...but that I had to be made eligible...she gave me an appointment to see a doctor...and another appointment to take some tests...told her about my situation... don't think she understood...she did send me over to Emergency Assistance...lot of good that did...guess no food is no emergency...besides, she forgot to let the folks know I was coming...everywhere else she sent me...had to sit and wait... sit and wait...and explain...don't these folks know I've got my pride?...what do they know about where I live?...I wonder how these folks got their jobs...I tell her I need a place to stay...and she sends me for some tests...and check this out...I got a letter from her...wanting to know if I'm still interested in services...she hasn't heard from me...and she's going to close my case....

COUNSELOR (to supervisor):

These clients...all these problems...I can't do anything about...think this is a welfare office...employment office... keep telling them...we don't have emergency services... we're not a crisis agency...what?...move my cases?

Supervisor (to administrator):

I know my statistics don't look good...we can't possibly move these cases any faster...so many problems...don't follow through on appointments...counselors are doing the best they can...takes longer to rehabilitate the severely disabled...studies show that...other agencies are having the same problem....

ADMINISTRATOR (to regional representative):

> It takes longer to rehabilitate the severly disabled... we're not the only agency with this problem...assigned an agency task force to study the problem...

The traditional model for delivery of rehabilitation services works poorly with disadvantaged clients as either they do not avail themselves of services or they do not appear to profit from services in the present delivery system. On the other hand, middle-class clients are likely to have had experiences that prepare them to readily understand their role in the counseling situation. This is unfortunately not true with a great many inner city clients.

Whether it is because of a lack of knowledge and/or sensitivity, there is a tendency for supervisors and administrators to ignore these facts and expect all clients to have a level of comprehension and motivation that, in reality, can be built only through a special cluster of experiences. Professional rehabilitation counselors in traditional agencies often react to the frustrations they encounter in applying the traditional system to the disadvantaged client with: (1) low expectations; failure anticipation and increased rate of failure to the self-fulfilling prophecy; or (2) with the notion that the disadvantaged cannot learn and do not care; or (3) with the conviction that it is all environmental due to impoverishment, economic insecurity, and segregation, one of which are the disadvantaged client's fault and none of which are, therefore, amenable to change.

THE STATE ADMINISTRATOR

As the leader of the agency, the administrator must make a commitment to become involved with those activities that will lead to the

maximization of resources for inner city nonwhite clients. Inherent in the mission of the vocational rehabilitation agency is the assurance of availability of services. This assurance cannot be delivered without the assurance of accessibility and continuity, two key dimensions of availability of service.

Once the administrator has made a commitment, it must be demonstrated by engaging in appropriate planning; development of appropriate policy and communicating those policies to all staff. The administrator who demonstrates his commitment will be serving as a role model for his staff. By virtue of the administrator's position, not only are they leaders of the agency, but leaders in the community. Hopefully, the administrator will strive to become a leader in the community, one whose presence, words and actions will reveal that an effort is being made to achieve closer cooperation between government and private agencies. Need for cooperation is vital between agencies that deal with health, economic and community matters. A concerted effort must be made to better utilize nonwhite community experience and to integrate this community experience with the formal system of rehabilitation.

THE REHABILITATION SUPERVISOR

As a part of the service system the supervisor, as advocate to the handicapped, needs to a catalyst in integrating services from all human service agencies on behalf of the inner city handicapped. The supervisor's efforts to become more visible and involved in the community will transpose and improve upon past service to the inner city disabled.

No reflection is intended beyond the inference that we must deal with out frustration of dwindling funds and resources and we must be

more creative, imaginative and dynamic as supervisors. The point is, there are infinite possibilities to improve service to the inner city disabled.

The supervisor can be the weakest or strongest link in the delivery of vocational rehabilitation services to the community. The outcome depends upon the posture assumed. If administrators present a strong program for effectively serving the severely disabled inner city resident, the thrust of that program depends upon the equal commitment of the supervisor. The supervisor must serve as the role model to counselors in that endeavor as well as communicate effectively and directly with the community. If the initiation of a more viable approach to serving the inner city disabled does not originate from the administrative ranks, the recognition of the need and program implementation demands an even stronger committed supervisor. The supervisor must convince administrators of the value of a special approach and convince counselors as well. The same may be said, and be true, for implementation of any special needs program. The emphasis being stressed by this study is that the population of severely disabled inner city residents must first be recognized as a special needs group, and also, that commitment is essential for any impact and any amount of success.

Supervisors can begin to interact differently with their staff and the community in order to effect more responsive interaction with the inner city client. Supervisors have to become program innovators and facilitators to make a difference in rehabilitating this population. The supervisor must become an activist in constructive efforts to insure the human rights of the handicapped and minority groups.

One of the many job responsibilities of an office supervisor is public relations - to make contact in the community, beyond the purpose of referral development, to make known the intent of the agency for community and legislative support.

The realization that must be faced and accepted for any measure of success according to Haubrich (1969) is that "involvement in a meaningful human partnership in a disadvantaged community is a stressful experience...the success of a program in a depressed area requires that there not be a failure of nerve. If intense involvement is to be developed, the person doing the work must be the kind of person who can take such stressful conditions." Supervisors may expect to encounter cynicism and resentment, if not down right hostility from their contacts with inner city residents. Disadvantaged groups have a right to be suspicious of every humanitarian cause when so often in the past righteous do-gooders have packed up their bags and moved on to the next "project" given a shift in governmental dollars and legislative concern. Once the challenge is accepted, there must be a continuation of effort for positive returns. There should be feedback, to counselors as well as to community contacts, reassessments, and directions determined. Supervisors should approach community leaders to elicit their acceptance and support of the rehabilitation district office. Counselors, in turn, must be trained by supervisors to carry this interrelationship building through with clients, the clients family, and any others affected by a program.

The supervisor has often been described as the "middle person." It has been said, also that the supervisor's job is not one to be envied, for they labor between the demands of the administrator above and the counselors beneath; that they are torn between agency rules and regulations

on one hand and client needs on the other.

However, the supervisor's job is also one to be envied. The supervisor has access to information from both sides, from the administrator and from the counselor, and hears both viewpoints. By virtue of this strategic position in the hierarchy, supervisors are afforded an oppurtunity to make the most valid recommendations for the benefit of the client and for the professional development and growth of the agency. Thus, with the proper knowledge, skill and sensitivity, the supervisor can become a facilitator of communications within the agency that will result to bringing about needed services for nonwhite inner city clients.

THE REHABILITATION COUNSELOR

The rehabilitation counselor carries responsibilities or works with clients, works with the community, and many administrative details that are inevitably involved with these two functions.

The rehabilitation problems of clients require individualized analysis and the making of a plan for each handicapped person. Any such plan will include the services of the worker's own agency, plus certain services offered by other organizations, each of which may make a valuable contribution to the rehabilitation of the client. In carrying out this plan, the counselor is bound to come in close touch with the personnel of many other agencies and organizations. If their efforts are enlisted on behalf of vocational rehabilitation clients, we must also be ready to assist other agencies with their clients. Understanding the structure, function, program and operating policies of other agencies is essential. While discharging vocational rehabilitations primary

responsibility for client work, the other agency may become more sensitive to the needs of the handicapped.

The amount of time invested by a worker in community work activities will be to a large extent dependent on the size and nature of the geographic area covered. Many of the functions carried by the supervisor in an inner city district or a closely knit metropolitan or suburban area are augmented by the counselor. Promoting good interorganizational relations and winning community support for handicapped people is part of the counselors advocacy role.

The duties of the vocational rehabilitation counselor are to locate physically and mentally handicapped within the community, determine their eligibility for services and assist them to obtain employment objectives. The inner city nonwhite has been under-served by the vocational rehabilitation counselors. Many factors on the part of the rehabilitation counselor as well as the client, contribute to this problem beginning from referral and continuing throughout the rehabilitation process.

RECOMMENDATIONS

State Administrator

1. Institute procedures calculated to incorporate positive attitudes towards involvement in the nonwhite inner city community into the task of all levels of staff performance.

2. Designate agency staff to participate in appropriate community organizations in the inner city nonwhite community.

3. Include in reporting systems, required from staff, evidence of services rendered to nonwhite inner city residents, problems existing, and recommendations.

4. Encourage creativity on the part of direct service providers who serve the inner city nonwhite clients.

5. Be visible in inner city nonwhite community.

Supervisor

1. Participate in nonwhite community civic, community or political meetings for purposes of gaining more information regarding needs of inner city that may be appropriate for vocational rehabilitation services.

2. Send letters of introduction to PTA presidents, principals, and other community leaders that may result in an "opening of doors" for the rehabilitation counselor.

3. Create an atmosphere in the community vocational rehabilitation office reception area that is educationally stimulating and motivationally enhancing to inner city nonwhite clients.

4. Engage in appropriate reading on use of volunteers and create community volunteers for the inner city vocational rehabilitation office.

5. Heighten own awareness and understanding of nonwhite communities; avoid subjecting counselors to your own personal biases or fears, if any.

6. Encourage freedom of expression among your own staff members regarding their fears or anxieties, if any, in order that counselor attitudes and skills may be examined if they are expected to deliver quality services to inner city nonwhites. Inner city nonwhite clients do not need the additional problem of an insensitive or unknowledgeable counselor.

7. Assist counselors in their personal growth and develop them by encouraging them to be specific regarding obstacles that they feel hinder their work, rather than to have them generalize out of frustration. This encouragement will, in turn, allow you to correctly assess, interpret, and make rational decisions and also, objective recommendations to your superior.

8. Serve as a consultant to community groups and organizations in projects that might require your expertise in the field of vocational rehabilitation.

9. Contact community legislators as an advocate for the handicapped.

Counselor

1. Identify and report blocks in services that hinder you from serving the inner city nonwhite client.

2. Heighten your own awareness and sensitivity to inner city nonwhite communities.

3. Represent your agency in community meetings.

4. In addition to developing outreach to obtain referrals, always look to those same referral sources for benefits you may be able to utilize for your clients.

5. Be willing to become a team member in working with community organizations.

CHAPTER III

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SERVICE DELIVERY SYSTEM

The uniqueness of the vocational rehabilitation program as compared with other social service programs rests on a proven service delivery model that requires maximum participation during each step over a long period of time. The direct benefit to society is reflected in the fact that there is over a nine to one return on every tax dollar invested.

Unfortunately, the system has not benefited the severely disabled in urban areas to the degree that it has the general disabled population. The inability of state directors and senior managers to provide leadership in implementing and adapting the system to meet the unique needs of this population is considered a major factor in the nonwhite population not receiving the full benefits of the program. Recognizing that there are serious cultural, environmental, and institutional barriers facing the population, state directors and senior managers must become more creative in implementing the program as well as in developing an evaluation system that will provide feedback of practices to line workers.

According to Owan (1978), Asian American, Spanish-speaking Americans, and Native Americans have been subjected to differential treatment and denied equal opportunity to participate in federally funded programs. They are among the most poorly served consumers of all public services today. The serious decline in the quality of services provided in federally funded programs has resulted in criticism from Congress and the public. We have failed through insisting that nonwhite groups change themselves to conform to bureaucracy; it is the bureaucracy that must adapt itself to the special needs of nonwhite groups.

Rehabilitation is a philosophy and field of practice which produces and influences outcomes that are motivated by and result from special helping relationships. Analyses of the many definitions of rehabilitation confirm this conclusion (e.g., Porter, 1950). The definition of total rehabilitation published by The Committee on the Processes of Rehabilitation (1947), states that "Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable." In brief, rehabilitation is concerned with helping handicapped persons to move toward increased human effectiveness through planned and coordinated services over a period of time.

In vocational rehabilitation, emphasis is focused on the realization of feasible vocational goals through the removal of those obstacles to employment and effective functioning as an employee and citizen. The successes in vocational rehabilitation attest to the significance of viable helping relationships (Hutchison, 1975).

Rehabilitation, then, is oriented toward achieving effectiveness in various life spheres by overcoming handicapping conditions through helping relationships which involve goals and coordinated effort.

Underlying rehabilitation are some principles. These principles give to rehabilitation its philosophy and direction and make it something special and important, especially when all of the principles emerge and interact to promote and actualize effective human functioning of handicapped persons. These principles have their roots in political philosophy, religious beliefs about and conceptions of humankind, and in other concerns about human nature, human rights, and human potential.

We are going to look at these principles as they have been expressed

by the Committee on the Processes of Rehabilitation (1947), of the National Council on Rehabilitation, by a psychologist (Wright, 1959), and by the National Rehabilitation Association (1961). We will note that these principles not only provide us with direction but can help us to understand where we are in that movement today. This is important, for today there is a good deal of frustration in the broad field of rehabilitation. There is also frustration in the various areas of this broad field, for instance, vocational rehabilitation, rehabilitation research, and rehabilitation of the severely handicapped. There is also frustration in the field of rehabilitation counseling.

Wilson, 1978, states that, "the frustrations in rehabilitation counseling grows out of an awareness of a discrepancy between the principles which guide rehabilitation and what rehabilitation is able to deliver in services and outcomes at this particular point in time and results from social changes which have required rehabilitation to serve handicapped persons not previously served in large numbers." Because of this, operations related to these principles must be clarified, updated and brought into vital balance with rehabilitation philosophy and principles.

PRINCIPLES FORMULATED BY THE COMMITTEE ON THE PROCESSES OF REHABILITATION

The Committee on the Processes of Rehabilitation (1974) listed the following nine basic principles for the field:

1. Rehabilitation should begin at the earliest possible moment after recognition of the existence of a continuing disability. In those cases in which an individual has had a disability for some time without having had the full benefits of rehabilitation, the

agency which first recognizes the disability as a factor which hampers the individual's fullest adjustment in society should initiate the process of rehabilitation.

2. All professional workers concerned with any of the processes of rehabilitation should take responsibility for identifying problems which call for rehabilitation services, for serving disabled individuals in their respective areas of competence, and for referring disabled individuals to appropriate agencies for services.

3. A satisfactory report of an examination by a physician competent in the area of the individual's disability should be secured before any rehabilitation services are undertaken. In the case of multiple disabilities, examinations by physicians competent in the respective areas are indicated. The findings of the physician should be the basis of all rehabilitation activities.

4. Rehabilitation should be an individualized process in which all rehabilitative activities are directed toward the particular needs of the individual in question.

5. Rehabilitation should be a democratic process in which the disabled person participates freely in planning for his future and makes the ultimate decisions about it.

6. The rehabilitation process should be characterized throughout by a constructive attitude on the part of each professional worker who comes in contact with the disabled individual, so that the latter is stimulated to return to his normal activities in the community.

7. Rehabilitation procedures should integrate medical, social and vocational diagnosis and activities toward the development of the disabled individual as a total personality.

8. Rehabilitation procedure should recognize the basic importance of the psychological adjustment and the mental and spiritual health of the disabled individual as an essential prerequisite to his successful return to maximum physical, social, and economic usefulness.

9. Each professional worker who participates in the rehabilitation process acts as a specialist within the skills of his particular field and recognizes the interrelationships of the several functional groups without confusing their functions.

PRINCIPLES FORMULATED BY A PSYCHOLOGIST

Wright (1959), reported the conceptualization of rehabilitation by psychologists participating in a conference in terms of the following twelve principles.

1. Value of the Human Being. The human being is a being of worth to be respected and cherished, no matter how severe his disabilities may be. He has a right to be assisted in the unfolding of his personality and the development of his potentialities for his own sake and for the good of society.

2. Membership in Society. The very nature of life implies physical and mental variation. Persons with a disability, like anyone else, should partake of the activities that society has to offer. Separation is indicated only under the considered evaluation of personal and social welfare, and then only as a temporary expedient until reabsorption into the community at large is possible. Acceptance on the part of society, rather than aversion and fear, is the emotional attitude toward which the rehabilitation effort is directed.

3. Assets of the Person. Although man is beset with physical and mental attributes which often interfere with his well-being, he also has a hearty complement of assets which can be supported and developed. The pathological processes in man's physical and mental makeup destroy, the healthy components restore. Emphasis on the latter is a formidable ally in ameliorating the former. Moreover, unless special care is taken, being sensitized to the pathogenic can leave one inadequately sensitized to stabilizing and maturity inducing factors.

4. Reality Factors. Behavior is a function of the person and the environment. The personal encompasses the attitudes, feeling, abilities, and other attributes that can be ascribed to the individual. The environmental variable refers to events whose source is seen to lie outside the person. These events are referred to as reality factors especially when their frequency makes them commonly occurring events. Difficulties in employment, are examples of reality factors with which a person with a disability must cope. The personal affective life of the patient cannot be ignored, but unless rehabilitation is geared to coping with the many reality factors in the milieu in which the patient will live, treatment will take place in an environmental vacuum.

5. Comprehensive Treatment. The many ramifications of adjustment to disability require attention to the individual's physical, emotional, and social problems, including economic matters and the nature of his interpersonal relations at home and in the wider community. The importance of "treating the person as a whole" becomes less of a cliche when it is realized that such areas are interdependent, improvement in one area often depending on improvement in others.

6. Variability of Treatment. Differences in the needs of persons with the same or a similar disability require variability in the overall treatment plan, rather than the inflexible application of procedures to all cases grouped under the particular disability category. General laws of behavior and disease entities, however, are important in understanding the special characteristics of the individual and his needs.

7. Participation of the Patient. Emphasis on the patient's assets, and the attitude of acceptance of, and respect for the patient, are two of the most important factors that have contributed to the increasing recognition that the patient must assume, to the degree feasible, an active role in both the planning and executing of his rehabilitation program. Among the foremost consequences are the restoring, maintaining, and enhancing of the person's initiative and self-respect.

8. Responsibility to Society. Effective living requires constructive effort not only of the person himself, but also on the part of society. Society is obliged to establish schools, hospitals, recreational facilities, and work opportunities that will meet the needs of all its members. Where special needs are evident, special arrangements to accommodate them are indicated. Provisions for these can be made by the family, the local community and the Federal government. Government, as well as private and voluntary effort, share the responsibility. Public education is the responsibility of the local community and nation as a whole.

9. Interdisciplinary and Interagency Integration. The problems of disability cover practically all the problems that one might expect to encounter in human affairs. Consequently, their solution requires the coordinated effort of many professions, close working relations among the various kinds of rehabilitation agencies, and integration of available community resources within the program.

10. Time Dimension. There is no point at which rehabilitation begins and other phases of treatment end. Rehabilitation is a continuing process that applies to the individual so long as he needs help, and to society so long as conditions exist that interfere with the welfare of any group of its citizens.

11. Ubiquity of Psychological Factors. The human being reacts cognitively and emotionally to events that befall him. It is well known that these reactions in turn affect the course of those events. One is compelled, therefore, to recognize that psychological factors are ever-present and often crucial in all aspects of rehabilitation--medical, surgical, social, vocational, as well as psychological.

12. Evaluation. Because the process of rehabilitation is complex, it must be subject to constant reexamination. Its review must be checked against such principles as those suggested above, as well as against new knowledge and understanding derived from ongoing research. This applies to rehabilitation as it concerns the individual patient and action programs as a whole.

PRINCIPLES FORMULATED BY THE NATIONAL REHABILITATION ASSOCIATION

The following nine "Principles of Effective Rehabilitation" were formulated by the National Rehabilitation Association Policy Committee (1961).

1. Scope. Effective rehabilitation is comprehensive. It presuppposes all the services necessary to enable impaired persons to function adequately as individuals, as family members, as citizens, and as economic contributors. It should be available to all disabled persons wherever the live and whatever their disability.

2. Joint Effort. Effective rehabilitation requires a rehabilitation emphasis in education, health, welfare, employment insurance, and recreation. It necessitates the coordination of the services of many public and voluntary organizations. It presupposes joint planning and action at local, state and national levels.

3. Professional Coordination. Effective rehabilitation requires a combination of professional and technical skills. It presupposes conditions that enhance

professional coordination, that encourage effective communications among the various professions, foster equality of status among them, and facilitiate cooperative effort.

4. Research. Effective rehabilitation requires constant self-analysis, stimulation, and evaluation. It uses research and advancing knowledge to evolve more effective methods of achieving rehabilitation goals.

5. Standards. Effective rehabilitation requires qualitative standards which assures a sufficient number of well-trained person, facilities adapted to special needs of impaired people, and effective application of services. It presupposes the availability of services when and where needed.

6. Public Understanding. Effective rehabilitation requires public understanding. Rehabilitation programming presupposes an understanding of disability, knowledge of rehabilitation objectives, and acceptance of disabled persons by the community.

7. Voluntary Effort. Effective rehabilitation requires united community action. The efforts of voluntary organizations and individuals provide needed services and supply vitality and new approaches to the rehabilitation movement.

8. Governmental Responsibility. Effective rehabilitation requires the assumption of major fiscal and program responsibilities by the federal government and states. This implies the appropriation of funds based upon needs and the progressive improvement of standards and goals in program development.

9. Administration. The satisfactory implementation of this function requires client-centered administrations that encourage the development of effective policy and enable administrations to deal effectively with other governmental and voluntary organizations.

NO POINT OF DISAGREEMENT

An examination of the principles reveals no point of disagreement. These principles indicate that rehabilitation has as its goal the total effectiveness of persons through the removal of handicaps. Total effectiveness touches all aspects of personal and social functioning.

Effectiveness is achieved through special helping relationships which require interaction and cooperation among professional workers and other significant persons concerned with the growth and development of the person receiving help. Rehabilitation aims and efforts receive direction from and can be evaluated in terms of their congruence with rehabilitation principles.

After a careful review of the philosophy of rehabilitation and the implementation of the principles, one must recognize that state directors and senior managers have failed to implement them sufficiently in the nonwhite handicapped community. Failure to implement those principles mention above have denied nonwhite handicapped of some of their basic human rights. Mathias (1976), challenges rehabilitation to facilitate the removal of barriers so that persons with disabilities can lead more meaningful lives because they are citizens with rights and obligations, among which are the following:

1. Every citizen with a disability should have the right to receive medical care for the protection of his or her well-being, and such additional special medical assistance as is required because of his or her disability.

2. Every citizen with a disability should have the right to recieve an education to the fullest extent to which he or she is capable, paid for and provided through regular channels of American education. They should have available special educational help as needed by virtue of their disability.

3. Every citizen with a disability ought to be able to receive training for vocational and avocational pursuits as are dictated by his or her interests and talents.

4. Every citizen with a disability should have the right to work at any job for which he or she has the qualifications and interests, including sheltered and other subsidized forms of employment, if such is appropriate to their needs.

5. Every citizen with a disability should have access to barrier-free public facilities, including polling places, public building, general mass-transit systems, supplemental mass-transit systems, social and recreational facilities, shopping facilities and entertainment opportunities.

The State/Federal Vocational Rehabilitation Program utilizes a delivery system that has been very successful with the physically disabled, but somewhat less than successful with the nonwhite handicapped. People whom in most cases are culturally disadvantaged. In many cases the nonwhite handicapped individual has been in and out of many social service doors only to find themselves at a dead end. In most cases the professionals in other social service programs are not clearly aware or understand the services provided by the vocational rehabilitation agency and therefore does not refer the disabled nonwhite client to the appropriate vocational rehabilitation agency.

With the broadening of the definition of the handicapped individual under the Vocational Rehabilitation Act, and the enactment of Civil Rights legislation, vocational rehabilitation agencies have moved to provide services to multiply disabled individuals. All evidence shows that the traditional pattern of services is, by and large, less effective for the nonwhite client from a culture of poverty.

The system starts out with a philosophy and an organizational structure which mandates that the client come to the agency for services similar to that of a large business. Once the individual gains access to the system, usually through a vocational rehabilitation counselor, they are confronted with an elaborate diagnostic process which presupposes that a prior developmental history, a personality that lends itself to following through a tightly organized system, and has

developed the common middle-class behavior patterns. The vocational rehabilitation program has as its unique goal rehabilitation adjustment of the handicapped individual. Rehabilitation as a treatment philosophy stresses implementation of a process through which maximum development of the handicapped individual's capabilities consonant with total needs can be accomplished. Rehabilitation as an action program has as its primary focal point the placing of handicapped persons into productive employment.

THE STATE DIRECTOR

Recognizing the complexities of the rehabilitation system, one must clearly understand that in working with the nonwhite handicapped individual, such a traditional approach to providing services may seem totally foreign to the individual during the initial phase. Therefore, it becomes the responsibility of the state director to determine whether the traditional approach would be used in the nonwhite community or new models and strategies will be developed. As in most instances, the state director must determine how the agency can be viewed positively by the nonwhite communities. Recognizing the importance of the image of the agency, the state director must develop a strong public relations program which reaches all corners of the nonwhite community. This calls for establishing meaningful communications with advisory boards composed of representation from nonwhite communities, clients receiving services, and professional staff having a direct contact and affiliation with such communities. Developing a program that will ensure this type of communication between the state director and the consumers of services will provide a mechanism to evaluate the effectiveness of policy

developed in delivering services to such communities.

Like all other organizations and agencies, vocational rehabilitation is beginning to feel compelled to provide proof of its effectiveness and worth to justify the nonwhite community's continued support. The various claims made for vocational rehabilitation can be somewhat confusing largely because it has not been exactly clear what level of demand or the type of proof the nonwhite community requires to justify its continued support of the vocational rehabilitation program. The nonwhite community is becoming more familiar with vocational rehabilitation's service delivery system and will require involvement in the policymaking process. Failure to recognize this most important ingredient will cause the state director a lack of support on the part of one aspect of its community that it is responsible for serving. Therefore, it becomes necessary that the state director and senior managers review the traditional approach of providing services to the nonwhite community and become more creative in designing new approaches.

In order to determine the approaches, a concentrated effort must be made in each state agency to develop new evaluation modules which will provide the data necessary to evaluate the effectiveness of the delivery system in the nonwhite community.

To accomplish this, one must reexamine each element of the process and determine its effectiveness.

THE VOCATIONAL REHABILITATION COUNSELOR

The principal link between the inner city disabled and the rehabilitation systems is the vocational rehabilitation counselor.

Effective counseling in general is difficult, and effective counseling of inner city residents is even more difficult. Many minorities do not have the patience and time for the passive and slow counselor. Often their concerns and problems demand immediate action. Inner city residents are oriented toward experiencing failure in the system. Therefore, they are suspicious of slow, long drawn out counseling sessions and long-range results. Effective counseling approaches for inner city residents should be action oriented.

In the actual counseling relationship, the vocational rehabilitation counselor with the aid of the counselee, should constantly assess the content of the counseling relationship. The vocational rehabilitation counselor should then repeatedly take action in helping the counselee and in getting the counselee to help himself. The two phases of a counseling process should be assessment and action. After assessment the counselor should prescribe and plan action for the client's change of behavior.

In some cases, the vocational rehabilitation counselor must involve the family in counseling sessions in order to assist their understanding of the role and function of the rehabilitation agency. Indeed, particularly in the inner city, the family (or extended family) can be a key source of support in assisting the rehabilitation counselor. It is imperative, therefore, to involve the family when necessary in the rehabilitation process.

REFERRAL

Many inner city residents have never heard of the vocational rehabilition agency. This is due, in part, to the fact that many minorities do

not read newspapers, magazines, or other printed sources of information about agencies. In developing referrals from the inner city, vocational rehabilitation counselors cannot be just desk professionals. They need to be involved in the community. Indeed, the vocational rehabilitation counselor must visit the community and get to know the community and not shy away from it. The vocational rehabilitation counselor must make the existing community system work for him or her by learning the membership organizations of the community, such as NAACP, Urban League, and, above all, the churches and community centers. Community leaders must be used as sources of contact in the community and as aids in making special appeals to those inner city disabled who may qualify for rehabilitation services. Posters, brochures, pamphlets, etc., must be placed in corner stores and other places residents frequent.

ELIGIBILITY DETERMINATION

Beginning with the initial interview, it is very crucial for the vocational rehabilitation counselor to be open minded and objective in dealing with any client, but especially the inner city residents. This is an opportunity to begin to explain the process, enlist the client's involvement, and emphasize that the client is a major partner in the rehabilitation process. What a client gets out of the process depends on what he or she puts in. Addressing this kind of involvement and participation is a way of letting the client see that the counselor views them as a capable individual whose decision-making ability is respected and encouraged. There is considerable distrust by the inner city resident with the bureaucracy, and the belief exists that the system will again rationalize rejection based on percieved irrelevant

issues. It is important, therefore, that the rehabilitation counselor does not project a negative attitude nor treat the client in a stereotypic manner, such as "You're not motivated," or "You have no aspirations."

Generally, these clients do not have the resources to finance the high cost of medical care, and, as a result, they are the most severely medically underserved group nationally. Their contact with the medical profession has been limited to mostly doctors in emergency rooms and outpatient clinics in local municipal hospitals. Sometimes a very strong fear of going to see a doctor exists. It is imperative, therefore, that the vocational rehabilitation counselor do a very thorough explanation of why the medical information is needed. In cases where the clients are already known by other social service agencies, such as Public Assistance, Medicaid, Compensation or Social Security, the medical information acquired by these groups should be used if there is not a great time lapse. When possible, appointments to get needed examinations should be arranged with physicians, hospitals, or clinics in the neighborhoods of the clients.

Psychological Testing

In determining eligibility, there may be a need for the counselor to purchase or provide directly a psychological evaluation. The inner city nonwhite client may react to being tested in a very negative, distrustful or fearful manner. Inner city residents distrust or feel suspicious about testing because testing has been used to screen out and to label minorities. It is key for the vocational rehabilitation counselor to be knowledgeable of the inner city nonwhite's attitude about testing. The counselor must not view the client with this attitude as unmotivated or not interested in services. Instead, the counselor

should be sensitive to the client's feelings and counsel the inner city client with sensitivity about the need and uses of the psychological testing to be performed. A crucial factor is that the counselor must understand and interpret the results of tests obtained. Implicit in the use of standardized tests is the assumption that all individuals have had the opportunity to learn the material in question, and this is often not true in the case of inner city nonwhites. Moreover, tests have been standardized on white, middle and upper class individuals. Thus, the tests are culturally biased and the same norms should not be applied.

Interest inventories may also be used to assist clients in identifying vocational choices. The counselor should keep in mind that minorities represent only a small percentage in a number of fields. Thus, the "similarity of interest" comparisions tend to be invalid. Here again the counselor must be careful in selecting vocational tests to be administered and the potential bias to the minority clients prior to testing. The counselor should not use psychological testing as all inclusive. Instead, the counselor should remember that in addition to using psychological tests, there are many other things that the counselor can do to gather information for the total psychological evaluation of each client. These include: gathering information about the client by observing his behavior during counseling interviews and other contacts; observing client's personal appearance and changes in behavior; and using client's educational and work experiences. It is also important for the counselor to know that the psychological evaluation is no way an isolated process but involves all of the variables mentioned above.

Inner city residents are also critical of the location they must go for services, and they often complain of the insensitivity of staff. Counselors must be able to empathize and show inner city clients that they care. Inner city residents have felt rejection long enough. Again the importance of counselor attitude must be stressed. A counselor must not promote dependency or treat the client in a condescending manner. Equally as important, counselors must remember not to force their value systems on the client. They must encourage the client to take responsibility for active participation in the rehabilitation process and effect a viable counselor-client partnership.

Developing Vocational Plans

In developing the Individual Written Rehabilitation Program with any client, it should be a joint responsibility involving the counselor, the client and the family (if feasible). Not including the client and family as partners in the rehabilitation process can create a situation which results in failure of the client to achieve the goals of the Individual Written Rehabilitation Program. Some clients proceed quickly and actively through the rehabilitation process. Others need considerable counseling effort and investment. In working with the inner city disabled and developing realistic vocational goals, vocational rehabilitation counselors will find that the latter is more common. In most instances, the inner city client has no vocational choice, therefore, needs assistance in determining a feasible vocational goal. The counselor should make useful recommendations that are not stereotyped to such vocational choices as janitors, porters, food service workers, and so forth. The counselor should counsel the inner city disabled client

towards reaching their fullest potential, including useful recommendations regarding training programs.

Knowledge of career options and the necessary preparations for career entry is often minimal. Lack of information may result from limited exposure because first generation college students are still common in minority families. A more serious barrier is a lack of interest in or attention to this process because of more pressing problems. For example, it is difficult to plan for the future when one's current personal, social or economic survival is threatened. Certainly, recent economic trends have resulted in high unemployment in blue and white collar jobs, and this has done little to sustain an interest in these areas. The counselor must prove to the inner city client that career planning is not only necessary but can lead to positive results in future employment. Expanding the minority clients' interests in career planning or making vocational choices is going to necessitate action and not merely advice on the part of rehabilitation counselors. The inner city client will respond more to intereaction with role model than by reading occupational handbooks or viewing films. The rehabilitation counselor must be able to identify minority professionals in various fields who are willing to share their experiences with clients. Other minority clients who have successfully completed the rehabiliation process may be used as peer counselors. Because peers have a powerful influence on client action, such groups should be used to provide needed role models as well as offer a supportive environment for discussing fears, expectations, and goals.

Racism, sexism, bigotry and class barriers continue to exist in many professions. The counselor should not overlook or underplay their

effect. Thus, clients should be alerted to the obstacles that may be encountered in career and mobility. Such information may discourage some clients, but those who persist will be better prepared to cope with and overcome barriers. Presentation of this information should, of course, include a review of federal and state employment policies and particular attention should be given to recently outlawed discriminatory practices.

Many inner city residents are overwhelmed by the prospect of choosing a profession. Some find it difficult to set priorities in terms of their interests and abilities. Others fear making a choice that would determine their future life-style, and others doubt the stability of current employment process. Finally, there are those who are unsure of their own ability. These are all valid concerns for any client. The minority client, however, has the additional problem of racism manifest by limited access to financial and educational resources and limited information. Under these circumstances, environmental manipulation becomes necessary.

The vocational rehabilitation counselor must make sure that sufficient resources are made available to the client. This includes the availability of financial aid and community resources that can assist the client in funding training. The client who may be a recipient of public assistance should be counseled on how to make the system work for their benefit, such as using the public assistance as income while in training and moving toward gainful employment. The identification or creation of other origins of support also may require the counselor to serve as an advocate. The client's personal resources (e.g., sense of identity and self-confidence) must be explored. These will shape the client's choice of a profession. The family can be used as a resource in assisting the client in achieving vocational goals. Referral sources

can also be utilized for resources to assist and assume responsibility in helping the client to keep appointments and following through with training and by providing the client with support if problems arise. All these resource areas must be identified and strengthened in order to successfully develop a worthwhile vocational goal.

Job Placement

The preparation of client for employment is a process involving activities and services throughout a client's rehabilitation as individual circumstances require and must begin during the initial interview. Four major approaches are utilized in job placement today:

1. Employer solicitation.
2. Teaching client job seeking skills.
3. Selective placement.
4. Client-centered placement.

These approaches are explained quite well in the Institute on Rehabilitation Issues (1975) document on the study of the Placement of the Severely Handicapped. There seems also to be four basic reasons for a counselor's negative feeling about placement, and the implications are very serious when the caseload includes minority disabled clients who begin the rehabilitation process with that major strike against them. The reasons listed by the study group are:

1. The counselor is unsure about the role of placement in his job.
2. The counselor is unsure about his ability to place clients; the client's ability to function on a job.
3. The counselor may feel unsure of the support he receives for his placement effort from his agency.
4. The counselor frequently feels that the agency's goals and expectations are beyond what he can meet.

In developing and securing placement sites for the inner city disabled client, not only is the counselor confronted with his/her negative feelings about job placement, but also the problems presented by the minority job applicant. Historically, minority job applicants have faced problems that were not unique to them but were more intensified because of skin color, national origin, or ethnic group. The problem faced by minority job applicants included, but were not limited to:

1. Racial prejudice and job discrimination.
2. Lack of proper qualifications, training and education.
3. Limited exposure to a wide range of career ladders.
4. Low self-concept because of the negative, social and occupational experience.

Obviously, all the problems mentioned are interrelated and often have a cause-and-effect relationship. For example, job applicants who have consistently been denied employment because or racial prejudice tend to develop an impaired self-concept. As a result, the applicant may be no longer interested in furthering his or her education or training because of past experiences of failure and rejection. Although the intensity of the problems mentioned has diminished for the most part, minority job applicants are still faced with the same range of problems depending on the particular situation.

It is important that the counselor conduct follow-up after placing the client on a job. Clients tend to become somewhat fearful and ask, "Will I be able to make it without public assistance?"; "Can I really make it on a job?" It is especially important for the counselor to be available to assist and support clients in dealing with these fears and any problems that might occur on the job. Clients must know that the counselor is still supportive.

In conclusion, we have discussed the interaction of inner city residents and the vocational rehabilitation counselor as it pertains to the rehabilitation process. It is clear that the inner city disabled client present many special problems to the vocational rehabilitation counselor. The counselor must have the skills, knowledge and experience to work successfully with this population.

Generally, the choice of language counselors use effects the image the clients have of the agency. Counselors who attempt to become familiar with clients by using excessive slang and profanity risk alienating clients further. Clients expect counselors to display conventional conduct. Counselors who offend clients by using inappropriate language not only disrespect clients but disrespect their profession and the agency as well.

Nonverbal cues as expressed by counselors are another method of communication that contributes to the image that the client has of the agency. While nonverbal cues are often unconscious, counselors must be conscious so as not to suggest through posture or gesture that the client/counselor relationship is anything but professional. To negate the value of nonverbal cues as they relate to communication is a failure to recognize communication as a process that involves more than appropriate words.

Attitude is defined as a way of acting that shows an opinion or disposition. Counselors who accept stereotypic descriptions of individuals often display their attitudes in the counselor relationship. Counselors who have negative preconceptions of minorities in general frequently deny services to clients who seem to fit the stereotype. This denial of services comes in patterns not easily broken. As a

representative of the agency, counselors determine who will receive vocational rehabilitation services. Attitude formation is greatly influenced by the media in this country, and unfortunately, the media representation is not always representative. Counselors who allow stereotypic attitudes towards clients to govern their behavior impede rather than facilitate the rehabilitation process.

As counselor dress, language and attitude are important, in view of the agency, these components in a less direct way affect the perceptions of the vocational rehabilitation agency held by outside agencies. Relationships are established among professionals as a result of commonly shared beliefs regarding professional standards and expressed in language and attitude.

The difficulties the rehabilitation counselor faces in providing services to the inner city nonwhite disabled are obviously multifaceted, but the rewards for overcoming the obstacles and returning a client to gainfully employed status remains the pinnacle of success.

RECOMMENDATIONS

1. From an administrative viewpoint for the expansion of services to the minority population calls for a period of "target spending." Therefore, until the programs become fully established, state directors and service staff must plan special programs with community organizations.

2. Appoint a task force of persons from the community to advise the state director on the development of policies and programs that will enable the nonwhite population to gain greater access to the vocational rehabilitation program.

   It cannot be assumed that effective programs for the nonwhite population will simply evolve from the setting up of special projects to serve them. As with any program, leadership marked with enthusiasm, flexibility, and realism are imperative to alter even when existing self-defeating attitudes are present with the staff or with the clientele.

3. The established vocational rehabilitation techniques with minimum, but necessary, modifications appear to work essentially as well with the nonwhites as with the white handicapped individuals.

4. The following considerations suggested by William English (1927) pertain not only to Black clients, but to any client group from a cultural minority. The disadvantaged disabled could be helped more effectively under the following circumstances:

    a. Such individuals must have increased opportunities to bring their cultures into rehabilitation facilities. Motivation and the chance for success are decreased when people cannot relate what they are doing to their cultural backgrounds.

    b. Rehabilitation facilities should be made more accessible to the poor, getting there should be made easy, hours should correspond to their schedules, information about the services should be disseminated, and referral procedures perfected in order to reach those in need.

    c. Counseling methods need to be creative, even unconventional for this group. Traditional counseling and psychotherapy techniques have not been effective with poor people; they were designed, of course, to help other groups with well-developed communication skills and considerable education. Recently, more attention has been given to approaches that do not necessitate verbal and intellectual skills in the client.

    d. Rehabilitation counseling with minority group members involves a number of unique issues. While it would be unreasonable to assign only black counselors to serve Black clients, agencies should recognize the need for special considerations for culturally different rehabilitants.

5. Rehabilitation personnel should take measures to obtain information and experience that will enable them to increase their understanding of Blacks, a disproportionate number of whom are vocationally handicapped. These measures, according to Ayers (1969) are to:

    a. Develop a desire to help Black clients and make a commitment to do so.

    b. Gather, within the agency, a collection of literature about Black history and culture.

c. Become familiar with the linguistic patterns of Black people.

d. Work against the dehumanizing procedures within the rehabilitation system.

e. Talk with many Black people and visit Black neighborhoods.

f. Create and take part in sensitivity training programs aimed at working on attitudes toward Black people.

g. Create and take part in training programs geared toward helping rehabilitation workers understand the nonwhite experience.

h. Listen to the statement made by nonwhite clients about rehabilitation.

i. Participate in community projects involving the nonwhite neighborhoods.

6. Counseling with the nonwhite disabvantaged disabled calls for special considerations. Among these are:

   a. Services cannot be limited to job training, placement, and medical evaluation, but must consider the "total" client including his social environment.

   b. Clients will not normally seek assistance unless intensive motivational and attitudinal activities on the part of the counselor and other interested persons are undertaken.

   c. Immediate and tangible assistance must be forthcoming or the client may drop out from services. Assistance need not be great, but it must be material. Talk of promise and further benefit will not suffice.

7. Elaborate vocational plans may be premature and either result in failure on the part of the client or delay the ultimate rehabilitation process and success. Initial short-term goals are more effective than lengthy ones. However, both short and long-term goals must be explored and developed.

8. Develop programs utilizing indigenous nonprofessionals as point of contact between the agency and the nonwhite disabled community.

9. Develop program emphasizing sensitivity training to overcome barriers between counselors and clients.

10. Develop programs based on the removal of artificial and unnecessary barriers such as overly complex rules, extended referral networks and physically distant agency locations.

11. Failures can be expected early in the rehabilitation process where clients do not follow through with expectations. This should not be used as a basis of termination services but as a means for exploring the problems behind these failures and taking remedial steps.

CHAPTER IV

DISINCENTIVES

INTRODUCTION

Regulatory and programmatic requirements within the Federal/State vocational rehabilitation program often serve as disincentives to the orderly and successful achievement of a disabled client's rehabilitation objective. The decade of the seventies witnessed an explosion of concern on the part of administrators, supervisors and counselors for removing or minimizing these disincentives. Inspite of these individual and collective efforts, disincentives continue to frustrate the system causing many users to drop out in advance of achieving their goal of self sufficiency or gainful employment.

Nowhere is the problem posed by these disincentives more apparent than within the inner city where large numbers of severely disabled and economically disadvantaged nonwhites reside. Forced to cope on a daily basis with problems related to economic and physical survival, these nonwhite clients often view rehabilitation as a noble, but burdensome intrusion on their life style and adjustment to environmental, social and economic reality. For them, minor delays, bureaucratic red tape, programmatic adjustments or inconveniences become major disincentives to continuance in a system whose carefully orchestrated steps make the goal seem distant and not worthy of the effort and commitment required for success.

There are many disincentives which cause inner city nonwhite clients of the vocational rehabilitation agency to withdraw from active

involvement in their rehabilitation programs. Disincentives can also take a variety of forms and be found in different settings. To appreciate the extent of their influence and impact on the client's decision not to participate, we need to analyze some of the more commonly observed disincentives, determine why they exist, and endeavor to forge techniques to overcome their negative impact.

This chapter will discuss some commonly found disincentives that have maximum impacts on inner city nonwhite clients of the vocational rehabilitation agency. While these are not all inclusive of the many disincentives found both within and without the inner city, they do have some unique features which when more fully understood should enable administrators, supervisors and counselors to more rationally and adequately cope with the miriad of difficulties inherent in working with this challenging population.

PROBLEM STATEMENT

Nonwhites residing within inner cities present a complex, heterogeneous mix of cultural, racial and economic differences. Their needs often extend beyond basic physical or mental restoration. Included in any random sample can be found persons whose rehabilitation problems are complicated by language, impoverishment, educational deficits, and familial disorganization, instability and difficulty. Primary needs for food, clothing, housing, child care, and related supportive services, plus traditional vocational rehabilitation services, are required to successfully rehabilitate these disadvantaged, disabled and often impoverished clients. The basic human problems, however, often are far greater than traditional vocational rehabilitation problems.

While these additional handicaps do serve to aggravate existing disincentives, they can also be a catalyst for identifying less obvious and more subtle disincentives which may exist on subliminal levels within the rehabilitation system. The need to identify and ferret out such additional disincentives is critical. Vocational rehabilitation agencies need to assess the tools, confidence and will of staff to overcome these roadblocks to program success and enable their meeting the critical challenges facing the Federal/State program as it moves to fulfill the promise of services to all handicapped individuals. Bold, flexible, imaginative approaches can and should be crafted at all levels--administrative, supervisory and counseling.

Our review of the disincentives identified below should provide some clues as to how best to cope with these frustrating impediments. It is also hoped that the review will enable a more critical look at these potential disincentives.

Six problems which frequently act as major discentives are:

1. Accepting employment causes reduction or loses in various supportive services or benefits.

2. Poorly defined legislation leads to confusing, ambiguous regulations and interpretations at national, state and local levels.

3. Enactment of similar benefit legislation and regulation provides confusion in determination of "first dollar" control and responsibility.

4. Uncoordinated services leading to recurrent delays and program interruptions and changes.

5. Ill defined short and long range vocational rehabilitation goals.

6. Administrative, supervisory and counselor insensitivity to cultural, racial, and life-style differences and needs of disabled inner city residents.

DISCUSSION

Many administrators, supervisors and counselors would prefer not having to face the difficulties inherent in serving severely disabled, nonwhite inner city clients. Less complicated and demanding caseloads, they feel, can be more easily gleaned from white neighborhoods and populations. Flexibility needed to succeed within the inner city is often seen as additional and unrewarding work. Disincentives in this setting can, therefore, become incentives for avoiding serving this underserved population. Failure to be skillful and innovative, becomes the rational for closing potentially successful rehabilitation cases prior to completion of essential services. Staff is also prone to accepting less ambitious and necessary services in the interest of reducing lengthened periods of dealing with perceived recalcitrant and unmotivated nonwhite clients resulting in rehabilitations reflecting expediency rather than achievement of a client's highest vocational potential.

Disincentives generally fall into one of three possible categories: Those caused by legislative or regulatory requirements; disincentives arising from the rules and practices guiding the delivery of vocational rehabilitation services, generally, and particularly within the inner city; and real or perceived insensitivity towards nonwhites on the part of the agency or its staff. While the impact of each of these may differ, in most cases they have a measurable, negative effect upon the energy and commitment of both the provider and consumer which operates as a feedback system leading to reinforced frustration and high rates of case closures, unrehabilitated.

Audits of vocational rehabilitation caseloads continue to show higher numbers of unrehabilitated case closures within inner city caseloads than in the general population of agency clients. They also show lower numbers of rehabilitants entering gainful employment with higher levels of homemakers than found in the general caseload. There is also a tendency toward utilization of sheltered employment for nonwhites with a sharp difference in expenditures, generally, and particularly as it relates to skilled training and expenditures for higher educational programs.

Additional study and analysis is needed to clearly distinguish between which of these factors are traceable to disincentives effecting both providers and consumers. Clearly, however, inner city nonwhites are not fully benefitting from the potential vocational rehabilitation programs offered for achieving employed status at levels above that of a homemaker or sheltered workshop employee. A measure of the impact such perception of the vocational rehabilitation program has within the inner city has yet to be developed. However, one can speculate on the effect such minimal outcomes have upon the motivation of severely disabled inner city residents, who have yet to enter the vocational rehabilitation program, but have intimate knowledge of other community disabled who have.

A factor often overlooked in any review of disincentives is the manner in which staff are effected by the client's reactions. Do they identify with the problem or the solution? If they identify with the problem to what extent do they blame the system, the client or themselves? How often are disincentives used as an administrative, supervisory or staff "cop out" for poor or "sloppy" work? To what extent

does the system reward solution oriented staff whose creative energies have enabled many inner city disabled nonwhites to climb out of poverty and into economic independence? The key question is whether the system itself acts as a disincentive for staff to be more willing to find solutions and thereby, to some unmeasurable degree, reinforce the disincentives felt by the nonwhite consumers?

These are serious questions which this chapter cannot answer but only raise as issues worthy of further study, research and reflection. Atkins (1979) highlighted some of these questions with her data showing the wide disparity in services to Blacks as opposed to whites being served by the Federal/State vocational rehabilitation program. The Michigan studies cited in this report also underscore the serious need to more fully understand the impact of staff disincentives as well as systemic ones if we are to ensure equity in serving the inner city communities from which many severely disabled clients come. A closer review of the disincentives cited above as problems may aid our understanding of other complex systemic and personality aspects of the vocational rehabilitation program.

ACCEPTING EMPLOYMENT CAUSES REDUCTION IN VARIOUS SUPPORTIVE SERVICES OR BENEFITS

Nonwhites residing in the inner city frequently come to the attention of the vocational rehabilitation program after their enrollment in an array of other human service programs providing major elements of their fiscal, social, familial, and maintenance needs within the community. They are, thus, very vulnerable to losses in these maintenance programs resulting from changes in income levels when entering employment. Because

the basic needs for food and shelter are threatened, clients frequently drop out of the rehabilitation program rather than suffer a possible net financial loss by going to work.

Skillful counseling and administrative supervisory support for an active ombudsman approach to solving this dilemma can measureably assist in minimizing or eliminating this disincentive. Each case differs, but threaded through all is the notion that some financial loss will be suffered through employment, which may or may not necessarily be true. Also, for many, work may mean no noticeable increase in income, thereby acting as a deterrant to entering the labor market.

Going to work has a differential impact based upon the role of the disabled within the family constellation. The head of the household going to work may have a lessened impact when the total resources and needs of all the siblings and spouse are reviewed. Differences caused by another member of the family increasing the resources may be deducted from the Aid to Families with Dependent Children (AFDC), food stamp or other supplemental income rolls. The latter often is more threatening to a family and acts to bring familial pressure to not be successful in completing a vocational objective.

Increases in costs to the family of expenses generated by work must also be considered as a possible negative factor. For the handicapped, unsubsidized transportation can prove expensive, especially when traveling from the inner city to more distant work centers. Counselors must seriously factor into their rehabilitation plan these potential roadblocks and recognize what the break even level may be for a client's entering the labor market. Cases should not be closed as unmotivated when the real litmus test of motivation lies in a more considered review of the gains and losses to a client or their family when making a decision to go to work.

POORLY DEFINED LEGISLATION LEADS TO CONFUSING, AMBIGUOUS REGULATIONS AND INTERPRETATIONS AT NATIONAL, STATE AND LOCAL LEVELS

Federal laws passed by Congress are frequently broad in scope and lacking in specificity as regards the day-to-day operation of programs. The task of defining procedures and rules is left to the bureaucratic structure through regulatory controls. Each department or agency of Federal government, therefore, issues a set of regulations spelling out the manner in which its programs will be implemented by state and local government and agencies.

No piece of legislation or regulation can be written which covers all possible contingencies and clearly defines every possible permutation in the service delivery system. Ambiguity can arise out of these processes and either inhibit or facilitate the orderly and expeditious delivery of services depending upon the agency or client's view of the regulatory imperative. For some it will be seen as a disincentive and for others as an incentive.

Interpretation is a key factor in carrying out any regulation. The tone is often set by the administration where off-hand comments may get coded as policy and procedural directives as they flow down the line. Consequently administration must constantly monitor what is occurring

Counselors need to take proactive approaches to interpretation of agency policies and procedures within the limits established by Federal legislation and regulation. They need to be familiar with these laws so as to question unclean advisories and procedures. Advocacy for the client must be their serious consumate chore and this imperative has to be maintained if inner city nonwhites are to be encouraged to enter and

stay in the program. It is critical that they enjoy the confidence of inner city clients, people who are not interested in the regulatory reasons why they suffer losses in supports. It is difficult for clients to understand why a trained professional can't get them a service they need.

Agreements and regulations setting forth the parameters of inter-agency cooperation and programmatic intersects are also subject to varied interpretation at the line level. Most such agreements, necessitated by legislative mandate, are general. They leave much of the implementation to the operational levels of agencies. If success is to be obtained in the rehabilitation within inner cities, then counselors and supervisors must constantly challenge the assumptions within these agreements and make them incentives for success rather than disincentives for failure.

FIRST DOLLAR CONTROL AND RESPONSIBILITY

In May 1978, the Fifth Institute on Rehabilitation Issues has as one of its prime study areas the topic of similar benefits. It defined similar benefits (1978, p. 7) in the following manner:

> The purpose of the similar benefits requirement is to maximize the total amount of vocational rehabilitation services available to handicapped individuals by encouraging and assisting vocational rehabilitation clients to seek and obtain other resources to which they are entitled before spending funds allocated to to the vocational rehabilitation agency.

The Prime Study Group goes on to point out (page 13-14) that administrators and counselors often view these legislative needs as creating additional paper work with only minimal benefits to be derived therefrom. In fact, they note, counselors perceive similar benefit requirements

as a barrier to effective case services and shy away from entering into cooperative program relationships with other agencies. Clearly, the similar benefits provisions of the vocational rehabilitation legislation, while intended to have beneficial impact upon the range and breadth of resources and services which can be provided, has resulted in some negative preceptions and reactions by staff of vocational rehabiliatation agencies.

Within the inner city, similar benefit legislation can have a large impact on the service delivery system. Key to understanding its impact is the knowledge that most government programs overlap. They also provide for utilization of other resources prior to their provision of specific services covered by similar benefit requirements. Medicaide, Medicare, mental health, CETA, amongst others, are prime examples of frequently used programs requiring utilization of other resources. Clients get caught in a service delivery shuttle requiring a continuing shifting from agency to agency for the provision of specific elements of their vocational rehabilitation programs, a clear disincentive.

In earlier days when cost factors did not prohibit vocational rehabilitation paying for most, if not all, services delivered to disabled clients, similar benefit requirements had no impact on the delivery system. It was also the case that clients entering the system were less often hooked into income maintenance programs since they came from less improvished areas of the city. Inner city disabled, as noted earlier, came to the vocational rehabilitation programs tied to a wide array of Federal programs mandating similar benefits.

How does one turn a disincentive into an incentive for ensuring the rehabilitation of the nonwhite inner city disabled? A good first

start would be to increase the administrative and counselor sensitivity to the problem. Counselors need to carefully analyse the impact on client's time, energy and resources of sending them long distances and into hostile agencies for minimal service needs. Where possible, vocational rehabilitation counselors should purchase these services and receive administrative support if it will facilitate the orderly and expeditious delivery of rehabilitation training and job placement. What benefit is there if clients enrolled in Medicaide to seek medical attention through social service agencies when long delays and incomplete medical attention is the result? Vocational rehabilitation can and should pay for this essential service when and where it can be documented to be necessary to the processing of the case and delay will cause hardship.

It is also critical that the agency and counselors develop good informal relationships with these provider agencies. Counselors must act as service facilitators if the motivation and confidence of inner city clients is to be maintained. Informality has always been the underpinning of vocational rehabilitation's success and it is even more critical in the inner city where client confidence is essential to continued involvement. By strengthening our informal network the potential disincentive can become an incentive for interagency cooperation and strength.

Counselors must carefully analyse the resources of clients when sending them outside their communities for required services. Frequently delays in being seen by agencies require unanticipated expenses for meals and other needs. Where clients from inner city areas must take these expenses from limited resources, disincentives occur and lead to a drop out.

Current and projected governmental trends suggest an emphasis upon deregulation and transfer of responsibility to local political systems and agencies. Argument both for and against such changes can be defended. However, these shifts in emphasis can be an opportunity for taking a system approach to service delivery. To that end, similar benefit legislation could be seen as a potential blueprint for future planning in an unregulated climate with concern for full involvement in the vocational rehabilitation program of the substantial numbers of handicapped nonwhites who reside in the inner cities of our nation. It can also serve to identify the roadblocks caused by several regulatory interpretations which are applied up and down the staff and administrative hierarchy of state vocational rehabilitation agencies.

DELAYS, PROGRAM INTERRUPTIONS AND CHANGES

One of the most frequently citied disincentives is the lack of smooth orchestration of a client's program such that they move steadily toward the goal and objective established in the rehabilitation plan. Too often clients find it necessary to negotiate a system at enormous commitment of energy, patience, motivation, and resources which for them appears to have only a limited output. For the white client whose program is interrupted there is greater understanding and appreciation of the complex interdependence of program and bureaucracy. The inner city nonwhite, however, lacking in the same exposure and experience with large organization perceived delays as another instant of frustration and/or denial and elects to not participate.

Motivation for many inner city nonwhites is at best fostered by long periods of counseling and is maintained by demonstrable increments

of change and improvement. Its tenuous grip on the inner city disabled is easily broken when minor or major breaks in programs develop. Additionally, the energy required to journey some distance from home to participate is easily redirected when program gaps occur and permit inner city clients to break the reinforcing chain that repetitive involvement has fostered.

Ample opportunity exists for the nonwhite disabled whose program is interrupted to attend to familial and other emergencies which found solution during their periods of program involvement. To remotivate such clients becomes increasingly difficult with each service interruption. Counselors must carefully organize programs for nonwhites from inner city areas and adminstrators and supervisors need to assure continuing budgetary and other agency supports to avoid interruptions and delays in programs.

This disincentive is often controllable with only minimal attention. The key is not to start clients until certain that all program components mesh perfectly in time and sequence. Clients need also to be active partners in the development and sequencing of services so as to ensure a higher level of understanding and commitment.

ILL DEFINED GOALS

Inner city residents, for the most part, have lived most of their lives on the cuttingedge of frustration borne out of limited resources, broken promises and unfilled dreams of a better life. Their ability to to make short-range sacrifices for long-range objective is minmal. Most of their existence is tied to a system of instant rewards as reinforcement for change. Success at negotiating the complexities of inner city

life is not always transferable to the outer system which they must penetrate if they are to achieve a meaningful rehabilitation goal.

Another factor seriously overlooked by counselors is the fear many inner city residents have, not only of journeying beyond the limited territorial boundaries of the inner city, but engaging in programs that may eventuate in another failure at achieving a goal. Commitment to long-range objectives is, therefore, not often possible nor desirable for these persons whose lives are determined by short-range outcomes on an almost daily basis.

Traditional rehabilitation planning acts as a disincentive for many nonwhite inner city people. The reward system which is predicated on output at some future, long-range period proves less than enticing for this population. Counselors must find a way of moving inner city clients more rapidly into and through various nonrewarding aspects of rehabilitation programs and establish paying or rewarding aspects earlier in the sequence to reinforce the client's motivation for continuance in the program.

Finding viable rewards for inner city clients is not an easy task. Competition from high reward systems that exist within the inner city is keen. Clients can often earn higher incomes from illicit activities than can be gained through rehabilitation programs. It is imperative, therefore, that creativity and skill be exercised in understanding the motivational system for such clients and foster a mechanism which provides intermittent and recurring reinforcement for this system on a short range basis.

Goals need to be clearly defined for inner city disabled clients. They must know where they are going, how they will get there, and when

they can expect to arrive. Counseling and reinforcement is critical at each stage and step along the rehabilitation continuum. Vague, ill defined goals will quickly lead to drop outs. Nonwhites need to be assured that the program is not another deadend which satisfies the providers and has little or no gains for the participant.

CULTURAL, RACIAL, AND LIFE-STYLE DIFFERENCES

A subtle, often overlooked disincentive to participation in vocational programs is the real or perceived insensitivity of counselors, supervisors and administrators to the unique cultural, racial and life-style differences of residents within inner city communities. Too often staff of vocational rehabilitation agencies make judgements and program decisions based on preconceived notions as to "what's best" for the clients coming from these communities, rather than the interests and demonstrated competencies of the client. Individual and group prejudices enter into the decision process and "color" the quality of service with frequent efforts to force inner city disabled persons to accept minimally beneficial or rewarding rehabilitation goals or plans.

Language differences present another difficulty for vocational rehabilitation personnel. Not only do we find a variety of foreign languages practiced within the inner city, but dialectical variations of the English language as well. These misunderstood variences and idioms give rise to misinterpretation and inhibit the close working relationships essential in a counselor-client relationship. Administrators and supervisors can compound the problem by not approving plans which aim at ameliorating some of these language difficulties through remedial education critical to training success.

Counselors should neither condemn nor condone but seek to understand what clients from the inner city are saying, on both a verbal and nonverbal level. In dealing with nonwhites, counselors must moderate disincentives and provide incentives through trust and understanding that will provide reasons for giving of time and energy to move toward job placement and potentially rewarding careers. Persons who can provide a rapid deployment of services, who are empathetic and understand the process and feel committed to its effectiveness are needed. Staff with these skills will bridge the gap between the suspiciousness of the nonwhite inner city disabled, and the offer of a better life through vocational rehabilitation training.

In talking about rehabilitation we often stress how successful it is. But we are dealing in the inner city with a heterogeneous group of people whose life-styles do not frequently include work. We need to identify, examine, explain and deal with these deviations from the regular noninner city caseload. Variation is the strength of the inner city. Counselors, supervisors and administrators need to capitalize upon these diversities. Then a program can be built on understanding and innovation, free of preconceived ideas and prejudices, and one which fits the life-style, cultural and racial inclinations and differences found in the inner city community. The challenge is real, the reward great.

RECOMMENDATIONS

Disincentives can become a "rational" excuse for limiting or refusing services to inner city nonwhite disabled persons. To the extent that this does not occur depends on the will and efforts of all

in the program. Administrators need to set the appropriate tone and direction for the agency while monitoring outcomes. Supervisors must actively and honestly work to carry out the objective of the agency for increasing services to inner city communities. Counselors must remain skillfully committed to innovation and change while showing a continuing drive to challenge the system and make it work for their clients. Each level of agency staff must do its part to foster success and reduce the disincentives to participation and achievement for nonwhites residing in underserved inner cities whose lives can only be enriched by the process and outcome of rehabilitation.

The following recommendations, while complimenting the suggestions offered throughout this chapter, are not meant to be all inclusive but only a starting point for the reader whose imagination and drive has been stimulated by the knowledge and awareness that it can be done.

Administrators

1. Administrators need to work closely with Congress to identify those aspects of the law which result in disincentives.

2. There needs to be a close collaboration between administrators and the Council of State Administrators in Vocational Rehabilitation (CSAVR), National Rehabilitation Association (NRA) and the Rehabilitation Services Administration (RSA) to foster legislative changes and programs which maximize the incentives for inner city nonwhite disabled persons to enter and complete vocational rehabilitation programs.

3. Administrators need to galvanize staff around issues related to vocational rehabilitation which have the quality of acting as disincentives to continuing involvement of inner city disabled in programs. Such leadership can influence the pressure for change in positive ways.

4. Administrators need to forge local coalitions to effect modifications in laws and regulations that act as disincentives.

5. There needs to be careful consideration given to the development of cooperative agreements with other agencies that conflict with Federal laws and act to increase disincentives rather than fostering cooperation.

6. Administrators have a leadership responsibility in that they must set the tone for active, productive agency participation in the rehabilitation--at their highest vocational potential--of nonwhite inner city disabled persons. They must also continually monitor the extent and degree of agency support for these efforts and take essential corrective action where needed.

Supervisors

1. Establish interagency written agreements on local levels. The written agreement should provide for periodic meetings between the district supervisors and liaison workers to address concern.

2. Establish liaison workers in the respective agencies to facilitate communication between local offices.

3. Provide training on vocational rehabilitation to other human service agency staff, and invite representatives from those agencies in to train vocational rehabilitation staff on their procedures.

4. Communicate with legislative representative covering the inner city on issues of disincentives to give support for the removal of such.

5. Agreements should address how inner city clients would benefit from services as entitled by each agency and not be penalized for incentives or monetary assistance from vocational rehabilitation to praticipate in rehabilitation.

6. Supervisors need to monitor caseloads to ensure that the maximum attention is being given to enrolling inner city clients in programs that are consistent, not with the counselors preconceived notions and prejudices, but with the demonstrated interests and potentials of the nonwhite disabled person.

7. There is a need to foster interaction and cross fertilization of ideas between white and nonwhite staff working within the inner city vocational rehabilitation office to broaden the base of knowledge counselors have regarding this complex population. Emphasis should be given to "weeding out" counselors who are not sensitive and understanding of the heterogeneous nature of this population and its differences in life-style from that of the professional counselor.

8. Local advisory committees need to be established to break down resistances that lead to disincentives.

9. Outreach to community groups, churches, local organizations, grass roots people, and other organs of the community is essential to maximize the incentive for client participation.

Counselors

1. Counselors should become more active through the development of counselor advisory committees for the purpose of eliminating the disincentives in utilization of vocational rehabilitation services.

2. Counselors have a professional responsibility to be well informed; they should ask for training in the area of similar benefits, legislation and regulations.

3. Counselors should act as change agents. Supervisors and administrators in the vocational rehabilitation system must continually be made aware of the difficulties clients face.

4. Counselors need to examine their prejudices and motivation for working with nonwhites in inner city offices and recognize the impact these may have upon the client and the potential for being a disincentive.

5. Counselors must forgo their rigidities and utilize maximum flexibility in finding solutions to problems faced by nonwhites applying for services from the inner city.

6. Inner city clients often see vocational rehabilitation as an entitlement program. Counselors need to actively explain and test client understanding, of what vocational rehabilitation can and does offer.

7. Client reluctance to getting involved must be recognized by counselors and dealt with in positive ways to reduce the disincentives created by the process and pace of vocational rehabilitation services.

8. Counselors need to be activists within the inner city community so as to be accepted and seen as a true ombudsman and advocate rather than another professional interested only in payday.

CHAPTER V

PUBLIC IMAGE

INTRODUCTION

Many social programs were developed during the last sixty years. The "furious sixties" was a particularly active period of social program expansion and experimentation both in the public and private sector. However, in recent years, a number of social programs have faded away or were severely trimmed back. Yet the State/Federal vocational rehabilitation program has endured.

In recent years, vocational rehabilitation has come under increasing criticism that it is not serving or is underserving certain groups of disabled individuals. In addition, governmental bodies are asking for proof of our cost effectiveness figures.

This chapter will discuss the lack of understanding of vocational rehabilitation by groups outside the vocational rehabilitation community. Then it will discuss what might be done by administrators, managers, and counselors to improve the public's awareness of the state rehabilitation program on the inner city nonwhite perception of rehabilitation.

PROBLEM STATEMENT

During their growth period, the public was highly aware of new "innovative" social programs. They were frequently in the news because of their promise of curing social ills. Often they had catchy names like WIN (Work Incentive) or the Manpower Development and Training Act. Names that suggested that they would put large numbers of individuals back to work.

In spite of seemingly professional public relations efforts, their failures became newsworthy. What brought about their downfall is worthy of reflection, discussion, and hopefully avoidance in vocational rehabilitation.

During the recent Federal budget development process, vocational rehabilitation came very close to losing a sizeable portion of its budget. Only through the concerted effort of several individuals and groups, was the State/Federal vocational rehabilitation story told in time to prevent severe reduction in the budget. It is a well advertised fact that there will be further severe cuts in social/welfare programs through at least the first half of the 1980's. These attempts to balance the budget will effect vocational rehabilitation if we do not begin to develop a better strategy of telling the rehabilitation story. A story that indicates, at least in part, that vocational rehabilitation, even in the short run, saves tax dollars particularly with nonwhite populations that have exceptionally high unemployment rates.

In these critical times, vocational rehabilitation needs the support of every constituency. Yet the study group's discussion indicates that nonwhite groups have criticized the services their inner city members have received. These criticisms towards rehabilitation agencies seemed to center in the following areas:

1. Lack of information about the mission and eligibility requirements of vocational rehabilitation.
2. Absence of knowledge about the services provided by rehabilitation agencies.
3. Difficulty, at the client level, in understanding the delay in the provision of services.
4. A belief that the agency will be insensitive to the needs and cultural values of nonwhite groups.

5. Lack of consistent follow-up of nonwhite clients in the vocational rehabilitation system and those who fall out of the system.

DISCUSSION

Strong public relations hype is no substitute for efficient and effective service delivery. Scientific evidence is lacking as to why well intentioned social programs have failed. However, there seems to be a number of commonalties of or grouping under which criticisms of these programs fall.

The most severe criticism of programs that failed seemed to center around:

1. Lack of high standards and skill in the selection of administrators and professional staff.
2. Weak budget and accounting procedures so that cost benefits analysis could not be made.
3. Absence of any recognized, tangible, and/or measurable goal or outcome.

We in vocational rehabilitation have, in large measure, avoided these criticisms. Yet few people know our story. Even when employers are questioned, few have heard of vocational rehabilitation as an agency or the services it provides. In the inner city, this problem is compounded by a number of factors. Social programs have come and gone and there seems to be a general distrust of any government agency. Yet, few inner city community leaders have been helped to understand the concepts or service delivery model of vocational rehabilitation. Those few that have heard of vocational rehabilitation do not seem to understand the constraints under which the program operates. Instead, rapid service delivery and job placement is expected. Further, we do not have an evaluation

system that indicates how effective (or ineffective) we are in the service delivery with inner city populations. Consequently, it is difficult to recommend specific change in our public relations effort. Instead, we first need an effective evaluation system that tells us what is happening with specific groups by geographic location.

One method of overcoming this problem (at least until better data is available) might be the establishment of an inner city advisory group. Such a group might be made up of lay and professional residents from the district office's service area. Membership should equitably reflect the ethnic and racial make up of the district office's population. This group could advise the state agency on its current public relations efforts and how to overcome cultural barriers which hinders transmittal of vocational rehabilitation's message. For example, the chairperson of the district office advisory group might also serve on the state level advisory group.

The expected outcomes of an improved effort in telling the vocational rehabilitation story are many. Among them is an increase in the number of appropriate referrals of handicapped people. Coupled with this should be a reduction in inappropriate referrals who still require considerable staff time and agency funds for screening purposes. Another expected outcome might be the attraction of more dedicated nonwhite professionals to both public and private rehabilitation, thus, giving "face validity" to our improved public relations efforts.

Administrator

There are many events at the state level which are deserving of media coverage. Yet no one hears about the Department of Vocational Rehabilitation's involvement. They do not get into the newspapers,

radio, or television. Administrators might follow the lead of their Congressmen. Every legislator informs his constituents when a contribution is made, big or small, to their district. Do we let state and federal legislators know the impact of rehabilitation dollars? Do we inform them of grants to private rehabilitation facilities in their district? Every two years a number of new state and federal legislators are elected. Consequently, constant attention to informing them about the State/Federal vocational rehabilitation program is necessary. It is important that they understand that vocational rehabilitation is a cost effective program, that it is an effectively administered and that highly trained individuals are needed to serve handicapped people.

Another constituency that needs information about vocational rehabilitation is the lay public. It is imparitive that they realize that vocational rehabilitation is a cost effective program and not another "give away" program. Frequently, programs for the handicapped are shown on television, in the newspaper or other mass media. Many of these human interest stories are about successful vocational rehabilitation clients. However, no mention is made of the State/Federal program and how it helped that individual. However, mention is made of the local nonprofit agency. These stories are excellent opportunities for informing the public about the service provided.

District Supervisor

How to reach people and groups varies widely from city to city and to audiences within a city. One way is to invite members of different cultural and ethnic groups to the district office. While learning about vocational rehabilitation they can inform us about cultural differences. Such cross fertilization can be invaluable for improving our image.

Many inner city residents do not read newspapers or pamphlets about our program. Consequently, they have a confused picture of rehabilitation or none at all. A method of bridging this gap is to get public information announcements on local ethnic or rock stations. In addition, human interest stories might be made available to ethnic newspapers or even neighborhood shopping or advertising papers.

Each community or neighborhood in a city has a local power structure. Often these are church leaders, directors of neighborhood recreation/service centers. Frequent meetings with these individuals have often proved helpful in improving referrals and removing barriers to service to clients.

Often little things are important in the perception of the helpfulness of an agency. For example, the friendliness of the receptionist or person who answers the phone. Many inner city residents must bring family members, including children, with them to interviews. In this case, accommodations might be made to provide a more enjoyable atmosphere. Such things as a few toys, comic books, confortable seating, a table might be provided. Such small accommodations may indicate to a client or visitor that vocational rehabilitation really does care for inner city residents.

Counselor

As the primary facilitator of services to the client, the vocational rehabilitation counselor is often the person with whom the client develops a long-term relationship. As such, the counselor projects the image of the agency. The responsibility this places on the counselor is magnified when working with inner city disabled persons whose repertoire of "important persons" is limited. In addition, as an advocate for

clients, counselors often develop relationships with other agencies establishing the counselor as the agency. While counselors don't often view themselves with such omnipotence, both clients and outside agencies who rarely come in contact with other vocational rehabilitation personnel, formulate attitudes and develop interagency relationships based on their perception of the vocational rehabilitation counselor.

The significance of such things as the counselor's dress, language, and attitude are particularly relevant to the image of the vocational rehabilitation agency. Counselors who attempt to relate to clients by dressing down as a way of demonstrating their affinity to their clients often relegate themselves to a peer status in the minds of their clients. The old adage that "familiarity breeds comtempt" is an appropriate sentiment in the client/counselor relationship. For example, it is our belief that clients who view counselors as they view peers are less likely to accept advice regarding appropriate attire for an interview. A counselor whose daily attire consists of blue jeans and sneakers is not an appropriate model. Since the vocational rehabilitation agency is a professional agency, the counselor has a professional responsibility to maintain that image.

RECOMMENDATIONS

Every opportunity should be made to inform the public of the impact of the vocational rehabilitation program. Specifically, a concerted and continuous effort should be made to inform inner city nonwhite disabled residents of their rights, responsibilities, opportunities, and the procedures under the vocational rehabilitation program.

Recommendations to Administrators

1. Every effort should be made to insure that legislators are fully aware of the activities and outcome of vocational rehabilitation. Since Congressmen change and even those with tenure oversee many programs, this must be a continuous effort. Information of programs stimulated by state or federal monies are particularly helpful. This is especially true when the legislator can state to his constituents that funds came from a budget he or she supported.

2. Every financial agreement, contract, or similar benefit agreement should include a clause which states, in substance, "No media coverage is to take place involving clients supported by this agency unless vocational rehabilitation's sponsorship is mentioned in a positive light."

3. One or more persons in the agency besides the administrator should be designated to speak for the agency in all media inquires. The designater person must use descretion in giving out information. In addition, these persons should request input from those in the organization who can assist in an official way. Further, they should actively seek out opportunities to inform the public about the goals and objectives of the State/Federal vocational rehabilitation program and be evaluated on their success in this endeavor.

4. Whenever legislation is enacted affecting the quality of life of the handicapped, designated administrators should disseminate this infomation to community-based organizations serving the inner city neighborhoods. For example, the State of Illinois has a "Rights Handbook for Handicapped Children and Adults," which delineates the law as it relates to the handicapped. This type of handbook should be made available in large quantities to every minority group organization through the state. These materials should be printed in the appropriate languages used in the state.

Recommendations for Supervisors

1. It is suggested that supervisors take the initiative to seek out and find community-based outposts in inner city neighborhoods to make services more accessible to the minority handicapped. The counselor should report to the outpost on a regular schedule, on the same day, and at the same time each week.

2. Activities of the agency must be disseminated to the community by the supervisor to avoid the possibility of receiving a distorted image as described by others.

3. Supervisors working in state vocational rehabilitation agencies should hold periodic community-based forums to interpret and clarify sections of the Vocational Rehabilitation Act, as it is amended, for the enlightment of the minority handicapped to their rights.

4. The supervisor, through channels, should encourage that board members visit the agency while the programs are in operation.

5. Supervisors should encourage staff to provide feedback and suggestions that will remove "bottleneck" where possible in order to minimize delays in the rehabilitation process.

6. Program pamphlets and other descriptive materials should be developed that clearly explains the vocational rehabilitation process to clients from nonwhite groups. These materials should describe the step-by-step procedure and the time involved to reach the goal of successful rehabilitation. Materials should also be developed that are informative at different levels of academic achievement. The goal of these materials is to clearly indicate that rehabilitation takes time and may be frustrating when goals seem to be a long way off. However, the counselor is there to help the client reach their established goals.

Recommendations for Counselors

1. Counselors must continually assess themselves to determine if their methods, behaviors, and attitudes give a clear message of the professionalism of the agency.

2. Counselors should be keenly aware of how the nonwhite client is perceiving them and what they are trying to accomplish with the disabled client. Constant concern for communication is necessary with all clients but is particularly important with the culturally different.

3. Rehabilitation counselors should avail themselves of any and all training on the cultures of clients with whom they work. If not provided by the agency, counselors working with disabled nonwhite clients, should request additional education and training by professional nonwhite organizations.

4. Counselors should provide immediate feedback to referral agents acknowledging receipt of the referral. Notes or or a phone call to the referral source indicating whether their referral is eligible or ineligible, and why, should help increase communications. Over time, inappropriate referrals should decrease as these referral sources become aware of the regulations under which rehabilitation operates.

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APPENDIX A

COOPERATIVE AGREEMENT
BETWEEN
MARTHA WALKER COMMUNITY CENTER
AND
VOCATIONAL REHABILITATION

APPENDIX A

COOPERATIVE AGREEMENT

BETWEEN

MARTHA WALKER COMMUNITY CENTER

AND

VOCATIONAL REHABILITATION

INTRODUCTION

Martha Walker is a church related, board governed, social and recreational community center. The center has served the needy, the handicapped and the poverty stricken people living in the John C. Smith Homes inner city area for the past 50 years.

During the past several years vocational rehabilitation and Martha Walker Community Center have worked together in an informal manner to enhance opportunities and experiences for the handicapped residents in the community served by Martha Walker.

PURPOSE

The purpose of this agreement is for vocational rehabilitation/ Martha Walker to work together on a formal basis to provide a pattern of services for the disabled living in the area which will appreciably affect the person's total development.

More specifically, the objectives are: (Again from a "total development" standpoint).

1. To improve individual and family life styles through extending the environmental alternatives.
2. To provide services not readily available in the community.

3. To foster individual growth through providing an atmosphere where individual freedoms and needs are recognized.

4. To provide an atmosphere of acceptance where positive self-concepts would be stressed through the recognition of individual worth and the expression of individual views.

5. And to help coordinate other agency services in the community.

AGENCY RESPONSIBILITY

In order to achieve these objective, vocational rehabilitation will:

1. Place appropriate staff in the Martha Walker Center at no cost for rent purposes but pay for phone service and all other staff needs.

2. Coordinate all vocational rehabilitation services with Martha Walker Center (and other community agencies) to remove duplication and increase cooperation.

3. Purchase available support services for clients from the Martha Walker Center where not obtainable through similar benefits, such as:

    a. Child care (baby sitting).

    b. Transportation.

    c. Attendant care.

    d. Etc.

4. Work with Center staff and others in promoting job development and job placement for the handicapped.

5. Establish in cooperation with the Martha Walker Center a referral and outreach program for the residents in the specified area.

6. Develop a public awareness program in meeting the needs of this group in coordination with other community agencies.

7. Help develop a volunteer service group both within and outside the immediate area.

Martha Walker Center will provide the following services in accordance with this agreement:

1. Child Development Component

    a. Day Care - Developmental day care program for children of working mothers. Ages 2-5 served from 6:00 a.m. - 5:30 p.m. Maximum slots 44.

    b. Pre-School - Half day program for children of nonworking mothers. Ages 3-5 from 9:00 a.m. - 12:00 Noon. Maximum slots 15.

2. Recreation Services -- A program designed to offer opportunities to individuals and groups for constructive and satisfying use of their time through a variety of recreation services. However, it is important to understand that the main emphasis of these activities is to promote sound personality development of the participants.

3. Adult Services

    a. Transportation - A 12-passenger van is operated daily by the Center from 7:30 a.m. - 3:30 p.m., taking people who live on limited incomes to the doctors' offices, public health clinics, welfare offices, social security offices, food stamp offices and the like.

    b. Auxiliary Services - This component provides a a variety of auxiliary services to adults, i.e., adult education, income tax assistance, supplemental food.

4. Social Services -- Provides a variety a social services to the families and individuals who are involved with the Center. These services include assistance with such needs as:

    a. Health problems.

    b. Financial problems.

    c. Emotional or psychological problems.

    d. Information and referral.

STAFF DEVELOPMENT

Vocational rehabilitation and Martha Walker staff will coordinate their efforts for providing in-service training to both staffs on a

planned and continuing basis to enhance meeting logical needs of clients in a prompt manner.

TERMS OF AGREEMENT

In view of the uniqueness (public agency and private agency) of this agreement and the circumstances under which it was developed -- in spirit as opposed to meeting an "intent" -- either party can discontinue its participation upon notification.

Date	Commissioner Vocational Rehabilitation
Date	Board Chairperson Martha Walker Center

APPENDIX B

IDENTIFYING
AND
RECRUITING
PRIORITY CLIENTS

A GUIDE TO
PLANNING AND EVALUATION

APPENDIX B

MICHIGAN STUDIES IN REHABILITATION

Utilization Series: 2

General Editors:

Don K. Harrison
Ralph M. Crystal

Identifying and Recruiting Priority Clients

A Guide to Planning and Evaluation

by

Juliet V. Miller and James F. Wargel

The University of Michigan
REHABILITATION RESEARCH INSTITUTE
School of Education
Ann Arbor, Michigan
48109

1979

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SECTION II

OVERVIEWING THE IDENTIFICATION AND RECRUITMENT PROCESS

This publication is designed to guide vocational rehabilitation agency management staff in the systematic process of identifying and recruiting vocational rehabilitation clients. This process can help a vocational rehabilitation agency respond to the following needs.

This Planning Process Supports These Agency Needs

* Identify and describe the potential vocational rehabilitation population in the agency's service area.
* Assess service needs of specific disability groups.
* Identify currently underserved and saturated disability groups to assess the extent to which the agency is providing equitable service.
* Establish yearly service goals for specific disability groups.
* Design and implement outreach strategies to support the achievement of the agency's service goals.
* Evaluate the effectiveness of these outreach strategies.

What is the Identification and Recruitment Process

Figure 1 on the following page gives an overview of the identification and recruitment process. Each section of this guide focuses on specific information and procedures which can be used at each stage of the planning process. Use of the guide will assist vocational rehabilitation management staff to complete the following planning, development, and evaluation tasks systematically.

* Design procedures to collect and use prevalance information.

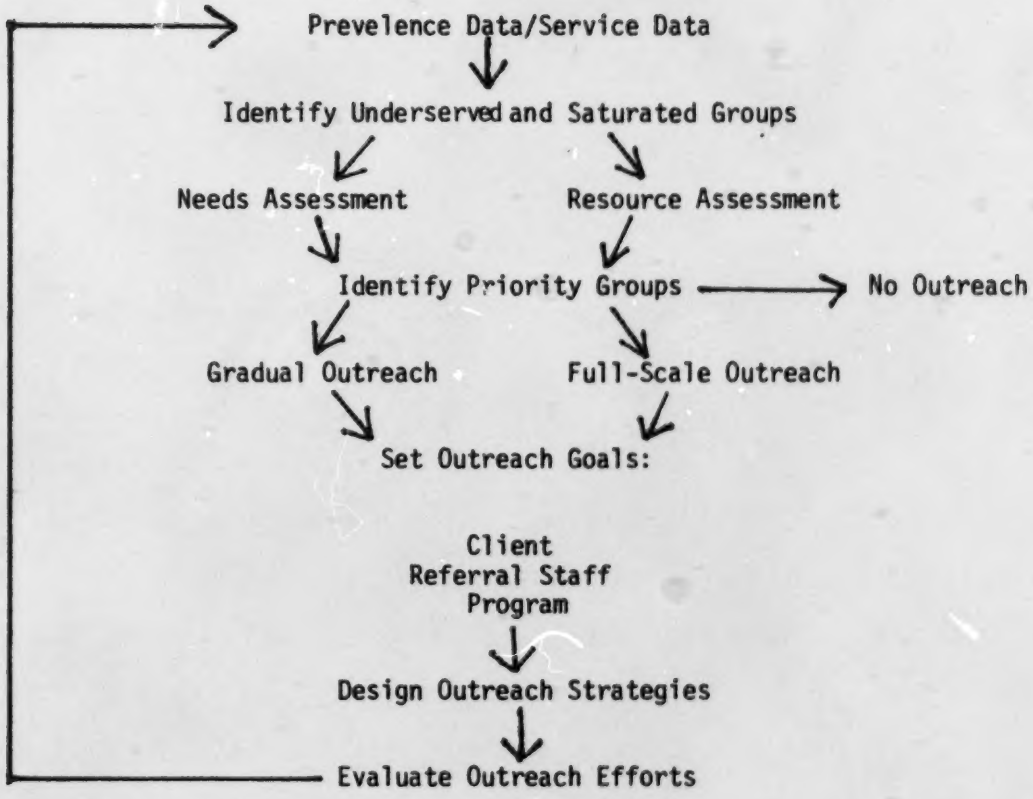

Figure 1. Identifying and recruiting priority vocational rehabilitation groups.

This Guide Supports Several Planning Tasks

* Use prevalence and case service information to identify underserved and saturated disability groups.

* Assess specific disability group needs using using several information resources.

* Use existing resource assessment information to assess the agency's capacity to provide vocational rehabilitation services related to identified client needs.

* Establish service goals and set goals for outreach efforts to insure achievement of those goals.

* Design outreach strategies to achieve service goals.

* Design and conduct an evaluation of the effectiveness of outreach strategies.

A Planning Activity for Your Agency

The following rating scale describes several purposes for using identification and recruitment procedures in a state vocational rehabilitation agency. Read each statement and rate its importance for your agency from 1 to 5 (1 being least important and 5 being most important). Discuss your ratings with other management staff and decide which staff will be involved in designing identification and recruitment procedures for your agency.

Identification of Shifting Priority Groups	Least Important 1	2	3	4	Most Important 5
1. To increase the number of severely disabled served and rehabilitated.	___	___	___	___	___
2. To focus services on clients not eligible for other federal or state services.	___	___	___	___	___
3. To identify the most appropriate referral agencies.	___	___	___	___	___

	Least Important 1	2	3	4	Most Important 5
4. To improve the representativeness of clients served to the potential population in need, i.e., to prevent overserved or underserved populations.	___	___	___	___	___
5. To overcome resistance to referral by professional service deliverers in other fields (e.g., physicians).	___	___	___	___	___
Identification of Eligible and Feasible Clients					
6. To eliminate creaming practices so that bias and limited experience do not screen out feasible clients, i.e., to screen in those feasible for service but not usually seen as such.	___	___	___	___	___
7. To develop outreach strategies for specific underserved groups of clients.	___	___	___	___	___
8. To maintain and build motivation for service during eligibility determination and plan development, i.e., to reduce 08 closures resulting from client withdrawal.	___	___	___	___	___
Better Recruitment of Client Groups					
9. To initiate service prior to degeneration or medical complications, i.e., to prevent secondary disabilities	___	___	___	___	___
10. To initiate service prior to an increase in resistance, i.e., prior to secondary gain and at a time when receptivity to service is highest.	___	___	___	___	___
11. To improve entry to service at the time when the expectations of service are most realistic.	___	___	___	___	___
12. To increase access to the services by the severely disabled and the multi-problem clients.	___	___	___	___	___

PREVALENCE INFORMATION

Rehabilitation services are intended for people with disabling

health conditions who can benefit from services. Planning rehabilitation service goals requires these types of information.

Information Needed for Planning

* What is the estimated number of potential vocational rehabilitation clients in each of several disability groups?
* What are the specific service needs of these disability groups?
* What resources does vocational rehabilitation have to respond to the needs of these disability groups?

Three types of information are needed to support the development of rehabilitation service goals: (1) prevalence information about the number and types of potential vocational rehabilitation clients; (2) needs assessment information about the actual service needs of potential clients; and (3) resource assessment information about available rehabilitation services to respond to client needs.

Criteria for Useful Prevalence Information

Prevalence information which gives accurate estimates of the potential vocational rehabilitation population is essential for planning. There are several factors which need to be considered when designing the methods used to obtain prevalence information.

What Staff and Money Resources Are Required?

* Prevalence information can be based on existing national data (estimated) or on locally collected data (measured). Measured prevalence information requires some type of survey of the state which the agency serves, whereas, estimated information does not. Measured prevalence information, therefore, requires greater resources in terms of staff time and costs. Staff time and costs can be reduced by targeting the study onto one disability group or other specific target populations.
* The potential rehabilitation population changes over time as new individuals enter or leave disability groups, the incidence of disability in

Is the Information Current and Accurate?

various groups changes, and members of disability groups move geographically. If valid service goals are to be set, prevalence information should be as current and accurate as possible. Measured prevalence information is usually more accurate and more current than estimated information. It is more accurate because it is based on data collected within the state served by the agency, whereas estimated information is based on national data. It is more current if collected periodically (e.g., every five years) since estimated information is based on information such as U.S. Census Data which is collected at longer time intervals.

Does the Information Identify Specific Groups by Geographic Area?

* The more specific the prevalence information is, the more useful it is in setting service goals. Some questions related to specificity are: Does the information distinquish between all people who have a health condition and those for whom the condition and those for whom the condition is disabling? Does the information account for individuals who have more than one disabling health condition? Does the information give numbers of disability types for local areas within the state? In general, measured prevalence information answers these question more precisely than estimated information.

Is the Information Compatible with Other Agency Planning Information

* To set service goals, prevalence information is analyzed in relationship to existing case service and resource information. Therefore, it is important to consider the following questions: Do the disability group categories used in prevalence data parallel the categories used in case record data? Do prevalence data indicate whether an individual will benefit from existing services? Do they describe functional limitations which can be related to available agency services? Again, measured prevalence information can answer these questions better than estimated information.

Measuring Prevalence Information

Since prevalence information is required for federal reporting as well as for state agency planning activities, all state agencies, at least initially, have used some technique of estimating the potential vocational rehabilitation population in their target area. These techniques are based on data from such sources as U.S. Census data or data

from the National Health Survey. Although estimating is a low-cost method of determining prevalence information, it does have problems related to the criteria of currentness, accuracy, specificity, and compatibility with other planning data.

Because of the advantages of measured prevalence data, it is important to consider the feasibility of conducting a prevalence survey. Here are some examples of studies which have been conducted by state agencies.

Ohio Used Trained Volunteer Interviewers to Reduce Cost

* The Ohio Rehabilitation Services Commission conducted a statewide telephone survey to obtain information about the incidence and prevalence of disabilities for each county in the state. Telephone numbers were selected at random to complete 12,500 interviews. The survey questions were brief but provided information about all members of the household (40,000 Ohioans). The survey not only provided planning information but provided public education about the availability of services. It was completed at moderate cost because graduate students were trained to be interviewers.

Minnesota Cooperated with Other Agencies within the State to Conduct a Survey

* A number of state agencies in Minnesota cooperated on a statewide survey which identified the noninstitutionalized disabled and described this population in terms of how their disability limits their ability to function in today's society. A statewide sample frame which samples housing units was developed along with a detailed survey form containing questions important for all cooperating agencies. Interviews were conducted in 2,335 households. The results provide valid estimates of the noninstitutionalized disabled population, identify types of functional limitations of the population, and describe major unmet needs of the population.

Factors to Consider in Designing Prevalence Studies

There are many methods which can be used to conduct prevalence surveys. Broad questions which need to be considered are:

Questions to Answer

* Who will use the information?
* What information will be collected?

Questions to Answer

* How will the information be collected?
* What sample will be used?
* Who will collect the information?

Who will use the information? Two options are possible. The information can be collected solely for the use of the vocational rehabilitation agency or it can be shared with other agencies within the state. Cooperative efforts meet the planning information needs of several groups and can reduce costs. However, it may be difficlut to gain the cooperation of other agencies and to gain agreement on what types of information should be collected.

What information will be collected? This is one of the most important design questions. Information can be collected on the incidence of specific health conditions, on the specific functional limitation resulting from these conditions, and on the needs for service resulting from these conditions. Prevalence information is most useful when it describes funtional limitations and services needed. This information is needed to identify groups who can benefit from service.

How will the information be collected? Prevalence information can be collected using written questionnaires, phone interviews, or household visit interviews. While the use of written questionnaires is the least expensive, phone or household interviews provide more complete and accurate information. These latter methods also have greater public relations value since interviews can also be used to describe available vocational rehabilitation services.

What sample will be used? Selection of the survey sample is important and should consider sample size, sampling information source, and coverage of various vocational rehabilitation service districts. Many states work with survey research groups to develop a sampling frame which can be used again in future surveys.

Who will collect the information? Personnel time required to collect survey information is the most costly aspect of prevalence studies. Three options are the use of agency staff, the use of low cost/volunteer staff, and the use of a private survey research group. The least attractive of these options is the use of agency staff because of the large amount of time required.

A Tentative Plan for Your Agency

Before deciding whether or not it is feasible to conduct a prevalence survey in your agency, it will be helpful to complete the "Prevalence Study Plan" on page 122. To complete the form, review the options listed below and explore these options with your own agency, other agencies within your state, private survey research groups, and rehabilitation training programs. Evaluate the options in terms of minimal cost, reasonable use of agency staff time, and maximum quality and usefulness of information.

1. Who will use the information?

   Vocational rehabilitation agency only.

   Vocational rehabilitation agency plus other agencies in state.

2. What information will be collected?

   Incidence of health condition.

   Functional limitations.

   Needs for service.

   Knowledge of vocational rehabilitation services.

   Interest in vocational rehabilitation services.

3. How will information be collected?

   Written questionnaire.

   Phone interview.

   Household interview.

   Other.

4. What sample will be used?

   Size.

   Sampling source.

   Coverage of service areas.

   Other.

5. Who will collect the information?

   Agency staff.

   Low cost/volunteer interviewers.

   Private survey research group.

   Other.

PREVALENCE STUDY PLAN

1. Who will use the information?

2. What information will be collected?

3. How will the information be collected?

4. What sample will be used?

5. Who will collect the information?

6. What agency staff and money resources are available for the study?

IDENTIFICATION/RECRUITMENT PLANNING FORM

-1-

Step	Goal	Persons Responsible	Groups/Persons to be Consulted	Procedures to be Used	Date to be Completed
1. Identify Target Client Groups					
2. Assess Needs					

IDENTIFICATION/RECRUITMENT PLANNING FORM

Step	Goal	Persons Responsible	Groups/Persons to be Consulted	Procedures to be Used	Date to be Completed
3. Assess Resources					
4. Specify Goals					

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IDENTIFICATION/RECRUITMENT PLANNING FORM

Step	Goal	Persons Responsible	Groups/Persons to be Consulted	Procedures to be Used	Date to be Completed
5. Develop Implementation Strategy					
6. Develop Program Evaluation Materials					

* * * * * *

APPENDIX C

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